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THE HOSPITAL WORLD

Vol. XXIII

Toronto, January, 1923

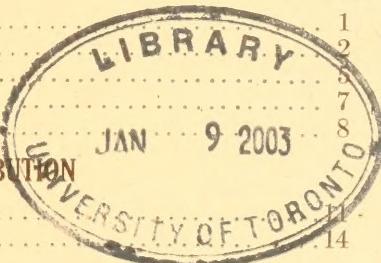
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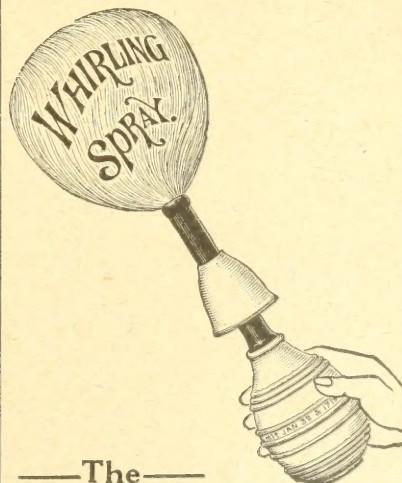
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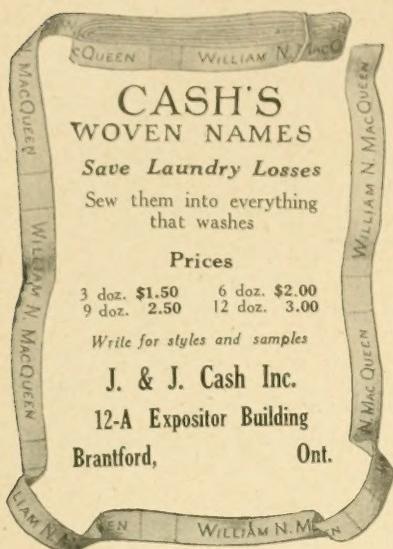
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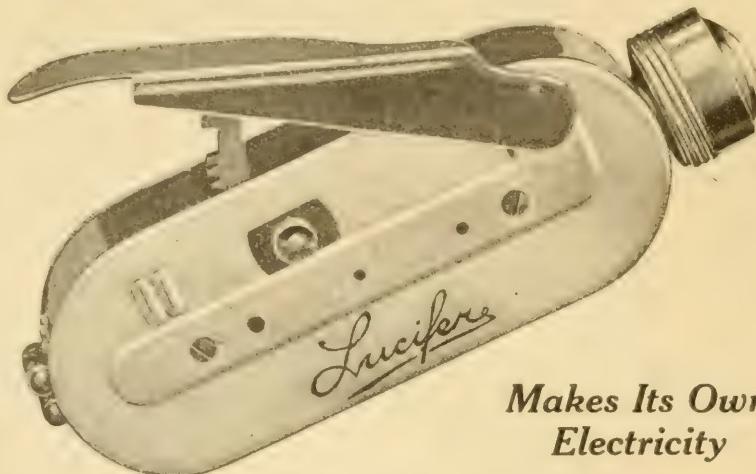
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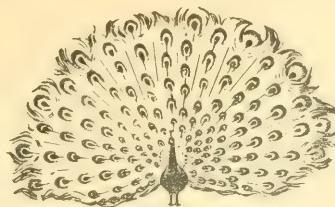
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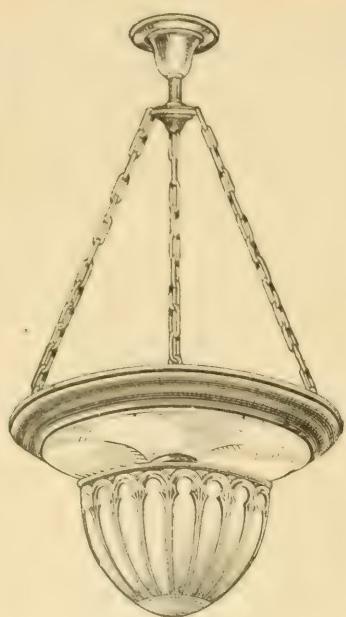
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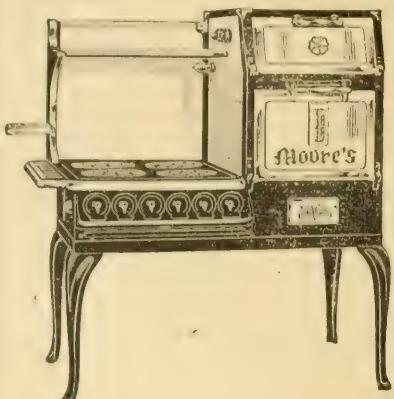
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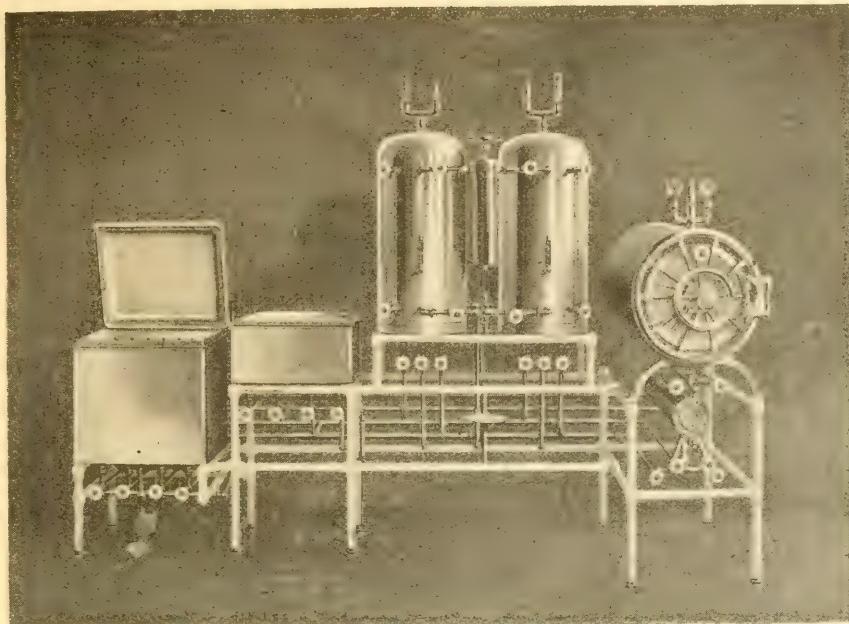
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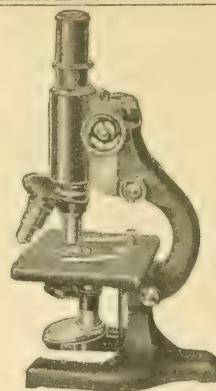
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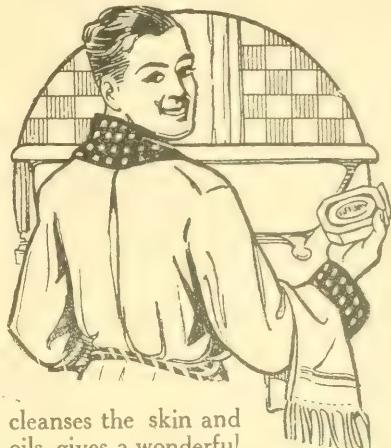
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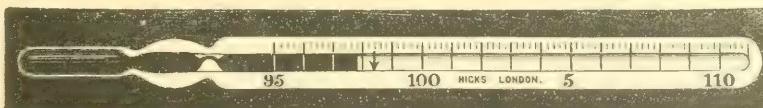
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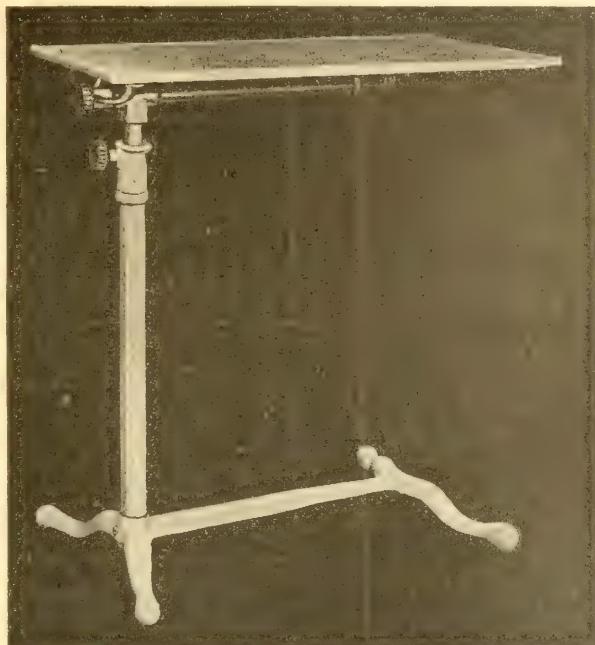
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The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire

Vol. XXIII

TORONTO, JANUARY, 1923

No. 1

Editorial

The Telephone Service

One of the most important posts in any hospital is that of the telephone operator. In the larger institutions, this official needs to be a mine of information. In the largest institutions he (or she) becomes often a mere perfunctory personage, merely switching the enquirer to the particular department from which information is sought. But these departmental phones need to be manned with the same sort of a person as is the main operator of a medium sized hospital, who often has to answer inquiries relative to the condition of patients, whereabouts of attending physicians and, worst of all (often), as to the location of the internes.

These officials need to be as meek as Moses, as wise as Solomon and as patient as Job. It is a nerve-racking business, particularly if they have charge of the outside system, and also of an independent house or inter-communicating system.

Prompt replies to friends inquiring about patients, to attending doctors who wish to find if there is room for a patient, or a spare hour in the operating-room list, or what not, makes greatly for the reputation of any hospital.

These telephone girls (for they say girls excel boys) ought to be well paid and treated with courteous consideration, should not have too long hours and be given plenty of holidays.

Every up-to-date hospital should have, in addition to the ordinary telephone system from the outside, an inter-communicating, independent automatic phone equipment for purely inside work. A signal system for summoning house doctors is also ideal.

Worthy of Imitation

Hospitals do well to often invite members of the profession within their precincts to let their visitors see and learn something of what they are doing.

The young surgeons of the Sick Children's Hospital, Toronto, recently were hosts to the surgical section of the Toronto Academy of Medicine and Surgery. Dr. D. E. Robertson presented patients suffering from osteomyelitis and actinomycosis. He wisely called attention to the importance of diagnosing osteomyelitis early. It is too often diagnosed and treated as rheumatism until irreparable injury is done to the bone, or even until amyloid disease has set in. He showed a patient suffering from the latter condition. By noting that the disease begins

at the epiphyseal junction and spreads away from the joint and also the pain, one is justified in exploring the part affected by cutting into the periosteum underneath which the pus burrows, drilling into the bone and evacuating the pus, and draining.

These patients usually show boils or sores in some other part of the body anterior to the osteomyelitis. The bone is injured, causing a lowered resistance and microbic infection is carried to this site from the other focus or foci.

The patient with actinomycosis had received a bruise on the chest from falling against the corner of a step. The wound did not heal, infection spread through the chest wall to the lung and downward over the chest to the abdomen. Iodide of potash had been given the patient in full doses, but the patient was still extremely ill. It was proposed to try salvarsan.

Dr. Bruce Robertson presented two children upon whom he had operated for pyloric stenosis. The symptoms were projectile vomiting, loss of weight, constipation, anuria and the development of a tumor. An incision through the thickened pyloris to the mucous relieved the condition.

He likewise presented a babe upon whom he had performed a subtemporal decompression on both sides of the head for cerebral haemorrhage due to birth trauma. The wounds had healed kindly, the symptoms had completely subsided, and every hope is entertained that the untoward after effects of

such a lesion will not appear—that the child will be hereafter physically and mentally perfectly fit. Dr. Robertson also reported several cases of extensive burns in which the patients were treated by ex-sanguination transfusion. These children had developed the toxæmia which generally ensues after extensive burns. Some 1000 cc's of blood were withdrawn and contemporaneously some 1200 cc's of blood administered from a donor, with a clearing up of the high fever and the nervous and mental symptoms, leaving the patients' burned area to be dealt with *secundum artem*.

Dr. A. B. Le Mesurier demonstrated on a patient the treatment of a fracture of the femur by the use of a Thomas' splint. Assisted by a house surgeon he set the supposed fracture very deftly in some six minutes. Every general practitioner should familiarize himself with this simple and successful method of handling this type of fracture. It is a marked improvement over the use of plaster paris or of the open method by bone plates. If the setting, after a day or so—even up to ten days—is found not to be quite satisfactory an adjustment and correction can be effected in a few moments. Not so with the plaster paris. Dr. Le Mesurier presented, also, a young child with its legs (one of which had a fractured femur) in a frame held at right angles to the trunk with adhesive up to the line of fracture and fastened to the top of the frame, counter ex-

tension by the body easily secured. This method he successfully uses in children under three years of age.

Equally interesting were the cases of patients shown by Dr. R. I. Harris, who were being treated for paralyses resulting from nerve injuries, and those of Dr. W. E. Gallie, who were being treated for fractures of the neck of the femur.

This was an evening *par excellence*. We are only sorry that, instead of some forty visitors—all of whom were delightfully instructed—there were not twenty times that number present.

We would suggest that this team of surgeons be asked to visit our county associations during the coming season and put on their show. It would pay.

Fine Medical Ethics

Apart from the inestimable medical value inherent in the possibilities of the new treatment for diabetes, there are one or two features in connection with its announcement that makes the Toronto profession particularly proud. The modesty of the discoverers, and their generous open attitude, through the Toronto University, toward outside medical research laboratories registers a high ethical standard.

The treatment was begun in January of the present year. When its beneficial results were sufficiently established, full information and formulæ

were forwarded to the Carnegie Foundation, and through it to large American laboratories, which were urged to immediate co-operation in the production of the insulin extract, so that a sufficient quantity might be obtained at the earliest possible moment for the use of the profession at large and the relief of diabetic patients everywhere.

The young and able discoverers who have been conducting their research under the ægis of the Toronto University, have turned over to that body their basic patents, so that when the processes are sufficiently advanced, licenses to produce will be issued, and the extract will be made available to the medical world.

In view of the very different procedure adopted concerning an alleged cancer cure of recent date, it is with the greatest satisfaction that the profession view the high and honorable course followed in this instance.

The young doctors whose research work has resulted in such great possibilities of benefit to humanity are following in the footsteps of Pasteur, Lister and other great scientists of the profession, who wrought, not for themselves, but for the world. Whether this extract proves a complete cure, an arrestment, or a palliative—and at this early date the discoverers confess themselves frankly unable to speak assuredly—at least they have given the fullest information to fellow-workers in the field and urged co-operation in procuring adequate supply.

Dr. Banting with his co-worker Mr. C. H. Best, have made their fellow members of the profession very proud indeed.

Professional Standing Orders

Under the editorship of Horace Korns, M.D., the Lakeside Hospital, Cleveland, has had published its professional standing orders and history forms. In their experience the hospital authorities have found that a system of standing orders does not tend to stereotype methods of treatment. In training house physicians, emphasis is laid by them upon the importance of fitting the system to the patient—not the patient to the system. Two years of experience with unified general orders has clearly demonstrated the superior utility of this method of administering the details of clinical work.

At the request of the secretariat of the American Hospital Association the type for this pamphlet is being held by the *Premier Press* of Cleveland. Any institution desiring copies may have them printed for it at reprint rates, substituting its name for that of the Lakeside.

This plan of presentation, the Lakeside people say, not only eliminates the constant conflict and needless reduplication of orders which inevitably occur when each service maintains for its own exclusive use a complete list of standing orders. It also represents, they maintain, a unity of endeavor among the services; and from the standpoint of in-

ternes and nurses, whose duties bring them into contact equally with all services, the advantages are obvious.

We recommend all hospital executives to write for a copy of this pamphlet. After reading it, we believe they will see the value of having such orders printed for their own use.

Why the Cults Accumulate

The Medical Faculty of the University of Toronto publish occasionally a tiny bulletin with some "bully stuff" in it. One contribution very worthy of the attention of some of our medical brethren is by the clever pen of Jabez H. Elliott, intituled "A Note of Warning." Here are two paragraphs at which the chiropractors, osteopaths, "scientists" and other such cults must chuckle when they peruse:—

"Quite recently there appeared in one of our provincial daily papers a letter from a patient under treatment in an Ontario Sanatorium. He was complaining bitterly that he was now in an advanced stage of tuberculosis with little prospect for arrest of the disease; that if he should be fortunate enough to secure some degree of improvement a long course of treatment would be necessary to fit him for even light work. Yet fully two years previously he had gone hurriedly to a physician's office when suffering from haemoptysis and had been assured that the bleeding was from his throat. Perhaps a year later

another haemoptysis occurred which was again passed lightly over by another physician whom he consulted. In each case without an examination of the bared chest, and with only a cursory glance at the pharynx, the "throat" was said to be the cause of the bleeding. He kept on with his usual work and it was only when notably losing weight and strength he again sought advice. By this time he had pronounced physical signs of pulmonary tuberculosis.

"Last year a man with a rather severe haemorrhage consulted a physician, as he was alarmed at the occurrence. The physician pulled out a chart, showed him the blood vessels in the throat and lungs, explained that the blood came from a small vessel in the throat which had burst, that it amounted to nothing and that he needed more exercise. Six months later he was found on examination to be in an advanced stage of tuberculosis and in a practically hopeless condition."

WANTED

There exists a vacancy on the Canadian staff of detail representatives of the Denver Chemical Mfg. Co., which will be filled January 1st. Applicants for the position should have medical or pharmaceutical training. One who speaks French and has had some experience detailing will be given preference. Salary \$2,400.00 per annum with a travelling allowance.

Applications for the position will be received at their New York City office, 20 Grand Street.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

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Editors:

JOHN N. BROWN, M.B. (Tor.), Ex-Sec'y American and Canadian Hospital Associations. Former Supt., Toronto General and Detroit General Hospitals.

ALEXANDER MacKAY, M.D., Inspector of Hospitals, Province of Ontario.
W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont. Consultant, Toronto Hospital for Incurables.

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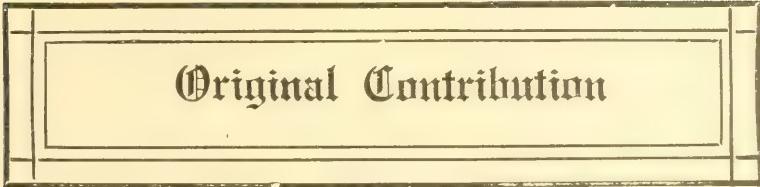
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MAUDE A. PERRY, B.S., Supervising Dietitian, Montreal General Hospital, Department of Dietetics.

A decorative rectangular banner with a double-line border. Inside, the words "Original Contribution" are written in a bold, serif font, centered horizontally and vertically within the frame.

Original Contribution

VALUE OF A DIET KITCHEN TO A HOSPITAL*

MISS H. HUNT.

Mr. Chairman, Ladies and Gentlemen:

This subject has not been chosen because I have anything particularly new to say but because it often helps us if somebody points things out as they see them. Now what is the value of a diet kitchen? Some people look on it as an expensive luxury, others as a necessary evil. The question is the value of a diet kitchen to a hospital. By a diet kitchen I do not mean necessarily a highly equipped room, but rather a room, even a small room, a mere pantry, where special things needed for special cases may be made and that this may be of value to the hospital. That is, the whole hospital organization is teaching the community because a hospital is not merely a building to be supported and of no value to the community except for people to come in and get treated there. Hospitals are of different sizes but it may be divided into two classes, first, the training school. The value of the diet kitchen is three-fold; first, the hospital profits by the diet kitchen in the training school. I am speaking of the more elaborate diet kitchen; it provides a place where the patients' special nourishment can be prepared in addition to the ordinary diets, and it also provides a place where diets such as for diabetes patients may be prepared. Now these diets have to be very carefully prepared, very carefully measured out and sometimes the diet is weighed. In the training school there is usually a trained dietician at the head, somebody who is experienced in these different things. The second advantage or value is the diet kitchen becoming the centre for control of food, for every

*Read at the Conjoint Convention of the Alberta Hospital Association and Alberta Association of Registered Nurses.

department needs some central control, and it can be more efficiently run if there is one person at the head, rather than two or three people, and nobody just looking after things. The third value is as a food laboratory, and just in relation to the remarks that have been made about the value of training nurses, I want you to remember this very important thing: if a nurse does not get her food training, probably she is a very dangerous person to let loose in the community. A nurse in training in dietetics was looking after a diabetic patient. The diet was very uninteresting. This nurse felt sorry for the patient and gave him a piece of bread and butter; trouble immediately, just because she had not realized the importance of dietetics, and that the person on a diet was on a diet and nothing else. Does not the nurse who takes training in the diet kitchen get training in setting trays, making desserts, and all sorts of special things, in quantities for one or many as the case may be? The nurses learn how to make a great part of the food which is served to the third floor, the private patients' food, and they get to learn how to make and serve a small portion, and to do it economically without waste. They also learn how to prepare infants' foods, and that is an important part, because a nurse is liable to be called on at any time. She may not prescribe for it, but the mother may say the doctor prescribed a certain food, and if the nurse is able to translate that immediately that is the value of the diet kitchen. Some nurses take institutional positions, such as head nurse on a ward and their diet kitchen training enables them to supervise the meals their patients get, because she knows by actual preparation of the food, what food the patient should have. Then with the special nurse she may, or may not, have to prepare the food, but can efficiently do so and the matter of serving a meal becomes quite mechanical. She gets things and sets the tray, and leaves the major portion of her time for the care of the patient. Supposing the nurse is asked to prepare some special dish, and she has little or no idea how to go about it. You can naturally see she is going to become unpopular with the person who has to do the work in the kitchen. Then there is the school work, and the Victorian

Order, who come in contact with the community at large, and she has a wonderful opportunity to show people the value of good food properly prepared, because she gets right into the homes, and in cases of sickness can prepare food and translate the doctors' orders if she has a proper diet kitchen training, so that the ordinary person can understand them.

Then, there is the other class, the hospital that has not a training school. They are of various sizes, the military and so on, and in most cases a trained dietician is in charge. She does not have to train the nurses, but there is a trained dietician in charge of the food, and in these smaller hospitals throughout the country, I would give this suggestion to them, that there be some small room where these special diets, soups and so on, may be prepared, because you probably know how difficult it is to keep on the good side of the cook; and who likes to have another person come into the kitchen and have a little pot here and a little pot there, using the very hottest part of the stove and one's own meal being kept back? So if you have a small room off the main kitchen where she can get in and make the soup or broth, or do the little things that she wishes, and not interfere with the regular meal routine of the hospital, it would be a great benefit. It takes five minutes to make an egg nog. If one person with special diet kitchen training, one person in charge of that department, and that department need not take up a nurse's whole time, because in the smaller hospital if one nurse had a definite place to work in, and a definite time to do it in, rather than each nurse having to spend a portion of her time, she could prepare three egg nogs in five minutes instead of three nurses spending fifteen minutes of the hospital time. If that is followed it means a considerable saving, in as much as several nurses making several little bits of soup, take very much more time. I think if the smaller hospital would have some little place and one person definitely in charge of these special preparations, you would find it would be more efficient and a great saving, not only in the food, because several things can be prepared if necessary for several people at the one time, and there is also the saving in energy required from the nurses chasing back and forth from the patient to the kitchen.

The value of the diet kitchen is a place for the preparation of special nourishment; saves time, energy and food and in the training school gives a place for the nurses to get their training.

THE KITCHEN*

T. J. MACIVOR, LONDON, ONT.

The kitchen serving room and dining room of an institution are so interdependent upon each other that if one is deficient it is likely to cause inefficient service. The space where the equipment is to be set up should be constructed to fit the equipment, not the equipment designed to fit the space allotted to it, and before any kitchen is laid out or construction started, have a sketch made showing equipment required for the number of people who have to be taken care of. It makes the work much easier; as often we find doors are in the wrong places, or so small that they will not allow equipment to go through, necessitating a lot of trouble when equipment is being installed. When the kitchen is made before the installation is planned for it, it often means expensive alterations. Another point; always advise that the kitchen should be made on the square; a long narrow kitchen is very hard to lay out to advantage, not only that, but it means delay in service on account of the help having to take so many unnecessary steps and in many cases are in each other's way. A small kitchen is the main trouble for so many dirty places.

The kitchen when being laid out should, unless it is unavoidable, never be placed in the basement. If it is to look presentable or be well ventilated the first floor is preferable, but in some of the hospitals it has worked satisfactorily on other floors for it is as easy to take the food down as it is up and they have the advantage of better lighting and ventilation. The kitchen should be so located that there is good ventilation through the side windows, and to be of ample size, for

*The author of this article is manager of The Kitchen Equipment Department, The McClary Manufacturing Co.

in summer even the well ventilated kitchens are warm and stuffy places for the workers. In hospitals, and hospital wards of institutions the diet kitchens are essential for the preparation of the trays for the regular dinner, and preparing diets for patients who are not allowed the general meal from the kitchen. They should be large enough to accommodate without crowding, the equipment necessary, such as diet table, gas or electric stove, refrigerator, sink, cupboard room and tray rack, also work table, etc.

Tile for the floor has proven most satisfactory and although more expensive at the beginning it will outlast the others. Concrete floors never look well and are unsanitary. They absorb grease and small particles of food on account of being so porous.

To prevent deterioration of the range it is advisable to put the range on a two inch brick or cement base and finish the edge with a cove tile. Unless this is done the water used for cleaning the floor will run under the range and rust it. Where the floor is of wood it is absolutely necessary to have something between the floor and the range. A mat made of two sheets of galvanized iron with a layer of heavy asbestos between will be found suitable; where possible have a proper foundation built.

The Sectional Cookers, Jacketted Kettles, Potato Peelers, etc., should have a depression of at least two inches in the floor, or else a built-up curb; on a wood floor a heavy galvanized iron pan; whatever kind of construction, always have it properly drained and connected to the sewer through suitable traps. Three things which are frequently overlooked in construction are: Sufficient Serving Room Space, Ample Scullery Space, Proper Bathing Conditions. How often have you seen a wash bowl with a clean towel in the kitchen?

Serving rooms are usually cramped and crowded. Little thought is given to provide ample scullery space; the main kitchen, to look spick and span, should have a separate room for light scullery work. Rough scullery work where possible and convenient should be done in the basement; the noise of machinery is confusing in the kitchen. The items for the basement would be the Ice Crusher, Ice-cream Freezer and Potato Peeler, etc.

Canopies, where possible, are being done away with. They are only grease catchers and are very unsightly in the kitchen as so few ever think of cleaning the canopy. If the kitchen is installed with a good exhaust fan and the ceilings are fairly high, they can be eliminated. If a canopy is installed it is almost necessary to have a heavy exhaust fan in the pipe or else the heat is thrown back on the chef before it can be taken away, unless the draft in the chimney is exceptionally good.

Ranges can be supplied with a down draft connecting to the chimney below the floor. It eliminates the unsightly piping in the kitchen and operates equally as well.

Suitably-arranged and equipped kitchens, serving rooms and dining rooms will promote food conservation and will give more satisfactory service than poorly-arranged and equipped ones.

No kitchen of any size should be without a Vegetable Peeler. One of ample size should be always specified, preferably with a motor, if there is enough work to warrant the extra cost for the motor. It will do better work than the smaller machine as the vegetables have more opportunity to come in contact with the abraders of a large machine than a small one. The Sterling is about the best on the market.

Dishwashing Machines not only wash the dishes in a more sanitary manner than hand washing, but also reduce the cost of dishes through lessening the breakage. The Crescent machine seems to be one of the most satisfactory on the market. It has so many features over the other machines and yet its simplicity is the big talking point. Another one is the size; we mentioned previously that the majority of kitchens were too small and every inch of space there is valuable, so the size or floor space of the machine is a big feature and requires consideration. The double wash is another point and where the Crescent has the advantage over most of the other machines is the direct rinse supply from the boiler; a basket of dishes is rinsed with water that has not been in contact with any dishes before.

Soiled and Clean Dish Tables can be supplied any size or shape according to requirements.

In laying out the equipment related processes should be grouped as much as possible to lessen the labor. The vegetable steamers should not be at one end of the kitchen away from the cook's table, or, if a kitchen machine is part of the equipment, should be relatively close together. Dishwasher should be in a convenient corner of kitchen for the help to pass by and deposit soiled dishes and take out new orders without any extra steps.

Before laying out the kitchen endeavor to secure all particulars necessary as to the style of the meal. The equipment will depend greatly on this style and the number of meals to be prepared. In an industrial kitchen the equipment would be entirely different to equipment for a hotel or hospital, as usually this kitchen would be for only one meal at midday, or if they were working two shifts a lunch would be prepared at midnight. Then where cafeteria is the style of service the kitchen would be differently laid out than for regular dining-room service. It is better to have the different appliances a little larger than necessary, than too small. When they are too small the service is never right and the chef is always in difficulties. Of course, the chef himself has a great deal to do with the equipment as some can use it to so much better advantage than others. Some chefs would be able to operate with two ovens in the range, where others doing the same amount or less would require an extra oven besides extra pieces, such as larger cookers and jacketted kettles.

No definite data has been secured whereby any range can be specified to take care of a certain number of people, as it depends greatly on the rest of the installation what size should be put in. Provision should be left in the kitchen for future extension as we have found that when new pieces are required, suitable space has been almost impossible to procure. The kitchen has been designed for their needs at that time but no thought for any extra requirements. In a hospital, for instance, it might have been found necessary to build on an extra wing and then the kitchen has been found far too small.

Installations sometimes reflect back on the outfitter; he has submitted specifications for the kitchen as he believes it should be but the Board of Directors, Manager or whoever has the authority, has changed it to his own ideas which

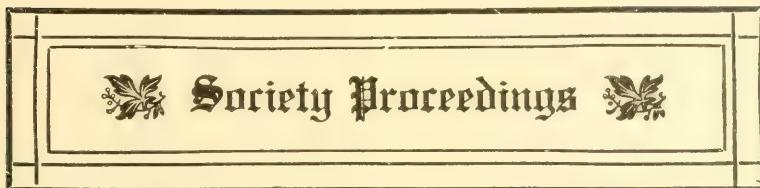
they find out later are not right; but anyone seeing this layout might think that the fault was with the outfitter, who was not to blame.

In many cases the specification is supplied and the outfitter is not allowed to deviate from the sizes or number of pieces.

When specifying equipment due consideration should be given to the method of heating the different units. If steam is available every advantage should be taken of it as there is usually a surplus; which will mean economy in the kitchen; not only that, but its operation is more satisfactory. A service table, commonly known as a steam table, gives better satisfaction heated by steam than gas or electricity. Urns are another article that are more satisfactory to heat by steam. Then there are pieces of equipment that cannot be installed, although necessary, if steam is not available; such as sectional cookers, jacketted kettles and roaster. A pressure-reducing valve should always be installed unless it is a low-pressure system. Ten to fifteen pounds of steam is ample for any equipment in a kitchen.

Then a modern kitchen has standard articles, such as sinks, of monel metal or galvanized iron; cook's tables, with wood or steel tops; pot racks, supported from the table or suspended from the ceiling; plate warmers, steam, gas or electrically heated; broilers, charcoal or gas; griddles; ovens for baking; baker's table, with suitable and sanitary drawers and bins; steam tables, with plate warmer below, any complement of fittings on top can be supplied. Steam cookers and jacketted kettles are other articles that are used extensively. Urns with a suitable stand for keeping cups warm, are used in a good many kitchens. Refrigerators of any size, freezers, ice crushers, butcher blocks, trucks, machines for the kitchen, both hand and power, and the miscellaneous small ware.

Not all these pieces are necessary in every kitchen but it is always advisable to have an experienced outfitter co-operate with you when you are planning out your kitchen. Blue-prints with complete specifications could be supplied.



CONJOINT CONVENTION, ALBERTA HOSPITAL ASSOCIATION AND ALBERTA ASSOCIATION OF REGISTERED NURSES

(Continued from last issue.)

WEDNESDAY, AUGUST 6th, 1922.

PRESIDENT.—We have represented at the Convention the following institutions and organizations. Lethbridge, the Galt Hospital and we also have Commissioner Freeman representing His Worship, the Mayor of Lethbridge. The General Hospital, Calgary, the Holy Cross Hospital, Drumheller, High River, Royal Alexandra, Edmonton, the Beulah Home, Lamont College of Physicians and Surgeons, the Society for the Prevention of Tuberculosis, the Alberta Medical Association, and we have a representative of the Alberta Nurses' Association from the Provost Hospital. It is well for us to realize we have a number of hospitals and institutions represented here. I may say that on behalf of the Minister of Health I am personally acquainted with Mr. Reid. He is a man whose sympathy in health matters is not excelled by any person in this Province. He is in sympathy with everything pertaining to the health movement and particularly I know he is interested in anything pertaining to the welfare of the hospitals of the Province. He is in sympathy, I am quite satisfied, with the movement of the Hospital Association, that has to do with hospital accommodation. I say this because following our discussion yesterday there was some discussion and talking that might lead us to offer some criticism which might be unfair, and I think as far as Mr. Reid is concerned he is not one of

that body. If you know him personally you will find him one of the most careful, sympathetic men you may meet. I say that in order that we will have a kind feeling which we should have toward the head of a Government.

If you will allow me to make my position as delegate clear, I would like to do so, as my position as delegate was also called in question. I may say I am here as a doctor, but apart from that I am a member of the governing body of the Holy Cross Hospital, and have been a duly appointed delegate by the Holy Cross. I am also a delegate of the Society for the Prevention of Tuberculosis, and am also here as President of the College of Surgeons of the Province, and in the fourth place I am here as your duly elected President, elected at your regular Convention last year, so I doubt if any delegate here can claim any better right of being here than I have myself.

It has been suggested that we could have the programme altered a little and go ahead with the consideration of those resolutions. Does that meet with the approval of the meeting?

Moved by Mr. Stickney, seconded by Mr. Williams, that the programme be altered as suggested by the President. *Carried.*

Resolutions from the Resolution Committee read by Mr. Dutton.

No. 1.—Resolved that a committee be appointed to be known as "The Special Committee on Legislation." This Committee to consist of: Dr. Smith, Edmonton; Dr. Archer, Lamont; Mr. Williams, Drumheller; Mayor Hardie, Lethbridge; H. B. Stickney, Drumheller, and with power to add to their number.

Moved by Dr. Lafferty, seconded by Dr. M. E. Hall. *Carried.*

No. 2.—Resolved that "The Special Committee on Legislation" appeal strongly to the Workmen's Compensation Board to revise their schedule of hospital fees so as to make the minimum fees conform to the actual average cost per patient per day of operating the hospitals of the Province for the year 1921.

DR. SMITH.—I would like to move the adoption, striking out "for the year 1921."

Seconded by Mr. Freeman.

No. 3.—Resolved that “The Special Committee on Legislation” appeal to the Provincial Government to enact such legislation as may be necessary to allow municipalities to keep in suitable homes within their own territory aged and incurable persons, and that the Provincial Government make the usual Government grant for such cases as is allowed for the hospitals. This to be a temporary measure until such time as the Government or the municipalities can make more satisfactory and permanent provision.

MR. FREEMAN.—I wonder if that is quite clear. I understand there are certain homes for old people for which there is a certain grant. In order to put these people into a regular hospital you have to have a doctor’s certificate that they are put there for senility care or actual sickness. It is a question whether a doctor could give a certificate for them to be put in a hospital. Now to send these people to these homes requires the spending of money out of your own town to support these people in other places. It was estimated they could be taken care of in a suitable home rather than a hospital, and the idea I had in my mind was we would get the same grant as is given to other homes for these people. The resolution calls for the same grant that they give to the hospitals for this purpose. Now do they give a grant for this purpose to the hospitals? You have got to get them into the hospital by certificate that they are there for some reason, possibly only senile decay.

PRESIDENT.—I understand fifty cents a day is the grant for an aged incurable person sent to McLeod.

DR. LAIDLAW.—The ordinary hospital grant is fifty cents. If they come from a municipality the balance is paid by the municipality, and if not, it is paid by the Government. You are asking the Provincial Government to give a larger grant towards the keeping of aged people than any other province. The Province of Ontario makes a special grant to the hospitals of that description paying 20 cents a day.

CHAIRMAN.—Are the Government not allowing fifty cents a day to the McLeod Hospital?

DR. LAIDLAW.—Yes, that is the case.

CHAIRMAN.—The idea was, we could take care of these people at home, and ask for the same grant.

DR. LAIDLAW.—It was considered necessary to keep that hospital open. The only way that it could be kept open was to send incurables there and pay so much. Otherwise from the looks of things in that district, that hospital would have to be closed.

DR. SMITH.—What is actually happening now is in a great many cases, they are being kept in the regular hospitals and the Government is paying 50 cents a day for these cases who go to the hospital, and they are a great expense to the municipality.

DR. LAFFERTY.—I think this Association should go on record as to how they should be looked after, and should make recommendations as to whether the patient should be a charge against the municipality, or against the Province as a whole.

MR. FREEMAN.—The idea is to take care of these patients in the most economical way. It is not difficult to find somebody who is willing to open up a home and take care of them at a minimum cost. Furthermore they can be near their own people. All we ask is that the grant the Government is now giving, that they give the grant to these people being taken care of in any other way. If you build a home for these people there is the capital expenditure and all that; and there are homes now that will take care of them and all these people need is some place to sleep and eat, and to be properly taken care of and there are lots of good people willing to take them in as sort of boarders.

PRESIDENT.—What do you wish to do with the resolution?

Moved by Mr. Freeman, that the resolution be amended by adding the words, "now receiving such grants" after the word "hospitals." Seconded by Dr. Lafferty. *Carried.*

No. 4. Moved by Mr. Stickney, that the resolution be taken clause by clause:

"WHEREAS, under the present Act known as "The Hospitals Ordinance," the hospitals of the Province of Alberta are under a serious financial burden owing to the fact that they frequently find it impossible, by any reasonable means, to

collect accounts for services rendered to patients from other municipalities, many of whom are ratepayers of those municipalities, and

WHEREAS, it is obviously unfair, that municipalities which are already providing hospital accommodation for the care of their own sick, should have to carry the burden of the care of the sick of other municipalities, and

WHEREAS, certain rural municipalities have a much larger percentage of residents who are not ratepayers, than have others, and

WHEREAS, the municipalities are in a position, by reason of their own present legislation, to make collection of any such accounts from patients who may be ratepayers of their own municipalities.

THEREFORE BE IT RESOLVED:

1. That "The Special Committee on Legislation" respectfully request the Provincial Government to alter the existing legislation that,

(a) Any hospital, after having exhausted all reasonable means of collection of their accounts from the ratepayers and their dependents from any other municipality, may collect such accounts from the municipality in which the patient is a ratepayer.

MR.^o FREEMAN.—Is that too ambiguous? What do we mean by "reasonable means?" To the extent of suit? Who is going to decide as to what is reasonable means?

MR. WILLIAMS.—I should think the Department of Public Health, should do that.

PRESIDENT.—You are dealing with principles now. You cannot expect to frame the Act for the Government but you give them the principle which you hold and if they consider favorably the principles they can have the act amended.

DR. HALL.—The idea is for indigents up to \$200 but for ratepayers the whole.

MR. STICKNEY.—"From any other municipality" that also is ambiguous. There should be a definition to show that the hospital district takes in many municipalities. "Com-

ing from municipalities in any hospital district, that they collect such accounts from the municipality in which the patient is a ratepayer."

MR. WILLIAMS.—Why discriminate against the municipality? Why not say account collected from the ratepayers within a hospital district? I think all ratepayers, whether coming from our municipality or some distance, should be on the same basis.

PRESIDENT.—They are now, according to the Act, can they not collect from their own ratepayers?

MR. WILLIAMS.—The act has reference to indigent patients.

Clause (b). That any hospital, after having exhausted all reasonable means of collection of accounts from patients who are not ratepayers in any municipality, shall be reimbursed by The Provincial Government, for the amount of such accounts at a stated specified rate per diem.

PRESIDENT.—This is, the Government would undertake to reimburse the hospital for those not tax payers, and to reimburse their own treasury, the suggestion is made that they secure their funds by taxation.

Clause 2. That this Association respectfully suggest to the Provincial Government that a Health Tax be levied upon such adults within the Province, who are not now contributing by other taxation.

AND FURTHER:

Clause 3. That this Association would be in favor of the Provincial Government appointing an official to give careful oversight and inspection of all such cases whose accounts are chargeable to municipalities or to the Government in accordance with the provisions of this resolution, with a view to

eliminating from the wards of the hospitals any cases that are not actually in need of hospital care.

Moved by Mr. Freeman, seconded by Dr. Lafferty, that Clause 1(a) be adopted. *Carried.*

Clause (b) "That any hospital after having exhausted all reasonable means. . . ."

DR. LAIDLAW.—The question of the appropriations is one that is rather unsettled. There has never been any agreement or understanding as to what the 50 cents a day is given for. In British Columbia the Government grant is on a sliding scale of 45 cents to \$1.50. The city of Vancouver gets 45 cents a day per patient, and in their hospital they take care of all the transients, also the patients from unorganized districts. They accept the Government grant and that is their understanding. In the Province of Saskatchewan the Government grant is supposed to be for the care of all transients, all those not domiciled in the Province. I am strongly in accord with the movement to get this thing settled, and settled in a way fair to the hospital. The larger the hospital the more incurables it gets and the municipalities, I regret to say, are very loath to accept any responsibility and I have been urging the Government to take some action against the municipalities, to bring stated cases and force legal decision as to the responsibility of the municipalities for their patients. It is rather difficult to get the Government to do that, but of course they are only human, and they get more support from the municipalities than they do from the hospitals. Moved by Dr. Smith, seconded by Mr. Cousins, that clause (b) be adopted. *Carried.*

Clause 2. "That this association respectfully suggests. . . ." Moved by Mr. Stickney, seconded by Mr. Williams. *Carried.*

Clause 3. "That this association would be in favor. . . ." Moved by Mr. Cousins, seconded by Dr. Smith. *Carried.*

Moved by Mr. W. T. Henry, seconded by Mr. Stickney, that the Resolution as a whole be adopted. *Carried.*

ROUND TABLE CONFERENCE.

CHAIRMAN: MR. WILLIAM DRUMHELLER.

MR. WILLIAMS.— I do not think there is any municipal hospital in the country who would think that they are absolutely supreme, and could not learn anything from the city hospital. Surely because we live in the country we are not going to be so small that we think we know it all, and I sincerely trust that any idea in regard to that may be dropped. The idea is to discuss matters of interest to the country and municipal hospitals, and if the members of the city hospitals will help us we will be grateful to them.

In regard to the membership at large I think this organization should be far better attended than it is. Dr. Hall has done everything he could do, and I think Dr. Hall and the present executive are entitled to a great deal of credit.

In regard to the municipal hospital, there are a few points I would like to mention, and which I might develop in the discussion later on. My idea is that there should be a taxation zone, with the hospital as the centre. I think that people living ten miles from the hospital, provided the right accommodation is given, should be charged at a higher rate than people living twenty miles away. The question of Poll Tax has already been dealt with by the Resolutions Committee, and the Convention at large. Then there is the question of enabling the municipal hospital to finance on a surer and safer basis. At the present time we levy taxes in exactly the same manner as the town and city. We cannot demand from the municipality a certain amount of money, on a certain date. The school districts are in far better shape than we are. If the municipality levying the tax consider that they cannot raise that money by that time they are allowed to make allowance for non-collection of taxes. The municipality is also given power to finance for the school. At the present time the Provincial Government have assisted us materially through the issue of debentures against the outstanding taxes to the extent of 50%. This is a great assistance for the present but I am afraid, much afraid, it is going to lead us into serious difficulty, as we are not in a position to create a proper

sinking fund, and the first thing we know the municipal hospital board will be collecting a lot of money, and spending for current account, whereas it should be going into a sinking fund. In other words, you are going to spend your assets and let your liabilities go. The question of a Government grant has been dealt with, and in regard to the Government grant it was suggested that a poll tax be levied to assist the Government in assisting the municipality. This Poll Tax could be collected through the municipality and returned by the municipality to the Government, and then it could be given out to the hospital giving special indigent care. In that way the country people would be relieved, and the people made to pay, themselves, and the hospital would not be in constant fear. We compel people to pay \$4.00 a year for education, why not make them make a small payment for the protection of their health.

DR. HALL.—As I understand it, you would have the employers—that is, each man would carry a card which would show he had paid the health tax, wherever he went, so he would not have to pay the second time.

MR. COUSINS.—Who collects the tax?

MR. WILLIAMS.—The municipality, in the case of an organized; and in the case of the unorganized, the Department of Municipal Affairs in the Government, and they remit to each treasurer.

DELEGATE.—How about the finances when the taxes are not coming across?

MR. WILLIAMS.—In our district we had a large number of unpaid taxes. We have received on several occasions assistance from the Department of Public Health, and advice on any matters in which they can help us. Last year we found the situation as Dr. Stanley states. Suppose there was \$25,000; in making the estimate, we figure that amount is going to be collected. We suggested to the Provincial Government that they impose some system of taxation, that the municipality would be compelled to pay us whether they collected or not. The Department thought that was rather drastic but helped us to this extent, that they allowed us to borrow by way of debenture the sum of 50% of the amount outstanding, as

at December 31st last year. The only difficulty I can see is that there is no way of creating a proper sinking fund to take care of the money, and a case might arise where a municipal board would spend that money, and would have no provision to meet their payments, which of course would amount to a considerable sum when you figure the interest.

MR. HENRY.—Is your assessment made on the basis of expenditure.

MR. WILLIAMS.—We are limited to \$3.50 an acre, and 3 mills on the dollar in urban municipalities. In our municipality we have the town of Drumheller, three other villages and several hamlets. We make an estimate, and figure the same as a municipal council. I follow the same principle as in the case of a municipal council, and so far it seems to work out well.

MR. HENRY.—If you only secure 50% of the unpaid taxes and the estimate is based on the whole expenditure, what do you do with the balance.

MR. WILLIAMS.—It gets down to the fact that we cannot estimate exactly. We estimate our expenditure on a liberal scale and I think it is the only safe way to do.

DR. STANLEY.—Would valuation on the basis of assessments not be fair.

MR. WILLIAMS.—No, the hospital is not always located in the centre of the district. These municipal assessments are made according to the distance or proximity to their own little towns. In the case of Drumheller property, good land is assessed at a higher figure than land closer to the hospital district, but not so close to the railway centre. The value of assessment in my opinion should not be in regard to the market town, but in accordance to the proximity of the hospital. At the present time these taxes are levied by us on an acreage basis but collected by the municipality on an assessment basis.

MR. COUSINS.—There would be a lot of land only good for pasture.

DR. STANLEY.—Is it not a fact in most of these rural districts, that it is the outlying patients that use the hospital a great deal more. You take a hospital located in an old established town, in one of our rural towns, where they have

homes fairly well equipped, is it not a fact that the people use the home and keep the patients there, and the people in the outlying districts and pioneer homes are the ones who do use the hospitals?

MR. WILLIAMS.—Yes, and there is the question of medical attention. If a man is away out on the edge of a district the doctor cannot go all over and look after the people at home, but at the same time these people are not in such large numbers as they are in close proximity to the hospital. The hospitals have been built in the closely settled districts.

DR. STANLEY.—What do you do with contagious cases?

MR. WILLIAMS.—We have prepared a small isolation hospital.

Q.—On what basis is the charge?

A.—Just the same.

DR. LAIDLAW.—What is your policy with regard to cases that cannot be treated in the hospital?

MR. WILLIAMS.—We generally refer them to the Department of Public Health for special advice. In the event of a case requiring special hospital attention and specialized care it seems reasonable enough that the patient should go on their own responsibility to where they are better equipped.

DR. LAIDLAW.—Supposing that patient had to go to Calgary. Do you pay the difference?

MR. WILLIAMS.—No, we pay nothing at all.

DR. LAIDLAW.—Where they go to the city should they pay the difference?

MR. WILLIAMS.—I think the municipal Hospital District establish their own welfare, and I think the responsibility absolutely rests with them as to the type of hospital they erect. I do not think if they put up a small hospital, that the hospital should provide special service.

DR. STANLEY.—Should they not pay that \$1.00 per day? A patient goes to the Holy Cross, taken from your hospital because there are not the facilities there. If he stayed there he would have that for \$1.00 a day. Do you not provide for or make any appropriation for these cases in any shape or form?

MR. WILLIAMS.—No we do not. I do not think we are morally or legally compelled to do so. Speaking generally I think the Municipal Hospital District establishes itself. The ratepayers know what they are doing and what hospital treatment they will get. We can hardly expect them to pay special rates. It could be carried so far.

DELEGATE.—If he has a right to that \$1.00 a day he does not cease to be one of your members and if he has to go to another hospital for treatment, should he not have a right to that \$1 a day?

MR. WILLIAMS.—I think to the extent that that hospital can give him.

DR. LAIDLAW.—This Association recommended the principle, to the Government, of the municipalities paying for their patients coming in to the hospital. Would you agree to your municipality paying for the patients going to the other hospitals?

MR. WILLIAM.—Not unless we could not look after them ourselves.

MR. COUSINS.—According to the resolution made the patient would be a charge against your district.

MR. WILLIAMS.—In the municipal hospital.

DR. STANLEY.—There is still an obligation. Supposing your place is crowded. The patient is not able to secure accommodation and has to go to some other hospital and he has to pay excess charges by reason of the fact that your hospital cannot provide accommodation. Perhaps your accommodation is taken up by outside patients up to 50% and yet why should the ratepayer when he cannot make sure of the hospital have to go somewhere else and pay a higher fee?

MR. WILLIAMS.—Absolutely. I consider we are under contract with every ratepayer to give them treatment according to the established hospital. If the hospital could not take care of any ratepayer and had to send him to another institution, I certainly think that hospital is financially responsible.

MR. COUSINS.—In the event of having many cases of that kind you would not have money enough to pay.

MR. WILLIAMS.—We would ask for a larger hospital.

DELEGATE.—If the patient goes to the city hospital the charge is against the municipal hospital, who gets the money from the ratepayer, and the municipality is responsible. Somebody is getting the money and the fellow who has got to pay it does not get it. According to the resolution we asked that the municipality be responsible for patients coming from that municipality to the hospital and have suggested a Poll Tax. The hospital collects this Poll Tax and figures they can be taken care of by the hospital there, but the municipality has got to pay the bill if the man goes outside that district. The Municipality has not collected any extra money; the hospital has, through the Poll Tax, for the purpose of maintaining this expense that we are talking about. The municipality has not got that money, and they are responsible for them.

MR. WILLIAMS.—If the Poll Tax comes in, the responsibility will be taken by the municipal district for the indigent patients.

MR. COUSINS.—It would not be taken by the municipality because the municipality would be compelled to pay the bill, but if by making the hospital people pay the bill, you would have legal redress against the municipality but not against the hospital.

MR. WILLIAMS.—I think in the case of overcrowding or being unable to fulfil your contract, then the hospital Board should undertake payment of the account.

MR. STICKNEY.—These gentlemen seem to be under the impression that the Health Tax would go direct to the hospital. The idea is to have the Health Tax paid into a special fund and then distributed pro rata to the different hospitals according to the number of indigent patients, so that relieves the municipality of all responsibility in caring for indigent patients.

DELEGATE.—It seems to me the question of responsibility is the broader one as to whether the hospital guarantees anything. They establish a hospital and vote on the size.

MR. WILLIAMS.—Naturally, according to the hospital scheme, it is voted on by the ratepayers and it is practically

their charter. They have an estimate of maintenance and size and they vote on it. Any hospital accommodation required further than that cannot be met.

DR. HALL.—There is no guarantee to the citizen that they will receive any further accommodation than they can take care of and why should they pay.

MR. WILLIAMS.—In the case of ratepayers you undertake to give accommodation at a certain rate.

DR. HALL.—Only up to the extent passed by your by-law.

MR. STICKNEY.—It is not a thing that would occur very often. If it were a regular occurrence we would immediately put up the proposition of enlarging, but if it occurs occasionally, particularly during certain seasons, it is merely an obligation upon the ratepayer.

DR. HALL.—Can you enlarge your hospital without a further vote? Supposing you have 100 and only have room for 75? What is your Board going to do, do they have a re-vote for the extra 25 beds?

MR. WILLIAMS.—You have to take into consideration the probable number of sick people which figure in the first scheme. If you take in too much hospital district the same thing would happen. You cannot send a boy on a man's errand. I think any hospital in a municipal hospital district should be compelled to take care of its own contract patients?

DR. HALL.—What do you mean by contract patients?

MR. WILLIAMS.—We have a number of special contract people. Anybody can pay \$10 a year and be entitled to the same advantages as a ratepayer. If they come to the hospital we charge a dollar a day and in addition we have a number of miners, twelve or fifteen hundred, who pay a proportion in to us every month. We are compelled under contract to take care of them and they assist us to finance very materially.

DR. HALL.—Is that a legal contract?

MR. WILLIAMS.—Yes, a mine contract has been approved by the Workmen's Compensation Board. It is absolutely under contract.

DR. HALL.—The contract with the ratepayer is the first call.

MR. WILLIAMS.—We have to be careful not to take on more than we can take care of. If we took on 2,000 and could only take care of 1,000, we would be in serious trouble.

MR. COUSINS.—The Medicine Hat Hospital was established entirely through subscriptions, and at that time we had an arrangement whereby anyone on becoming a member of the Hospital Association was entitled to free hospital service for a certain length of time. That would be much the same way as making arrangements with your miners.

(To be completed in next issue.)

ANNUAL CONVENTION OF THE PROTESTANT HOSPITAL ASSOCIATION

Atlantic City, Sept. 23, 24, 25, 1922.

Great events were staged for the hospital workers in Atlantic City during the meeting of the Protestant Hospital Association.

The General Secretary wrote: "We feel that in coming together in this city we have come to the right place to take the 'tired' out of our bones, the 'dull' out of our brains, and the 'sag' out of our souls. And if there is anything else we need to get out of our systems we can drown it in the briny deep. Here, along the Board Walk and in Convention rooms and halls, interest will be at boiling point every minute."

Our chief interest gathers around a greater efficiency and potency of Christian work in our hospitals. We are interested in all other hospitals, of course, but are assigned to a task which none other can assume for us.

The correspondence with my office the past year reveals the faith of good men and women in developing the work to which we have addressed ourselves. They believe that the influence of a Christian hospital is a fountain of good, from which a perennial stream of healing flows. They maintain that our purpose should be to develop the scientific training

of nurses, strong Christian characters for leadership, benevolent principles for action, and efficient hospital service for every patient.

The Protestant Hospital Association is functioning to this great end. Already a number have written that they have been specially helped by our publicity and efforts.

For Example: Our Educational Programme. The General Secretary has endeavored to reach all Protestantism through articles sent to the leading church papers of all communions. There are 112 church papers on my list, and most of their editors have printed these articles, while a few have placed them in that little drawer where they keep things too sacred for the human eye.

Our Association has made the first direct attempt to interest the 171,000 ordained protestant ministers and 26,000 lay preachers of America, as a whole body, in hospital care of the sick. If it be charged that they ought to be interested anyway, the answer is, they cannot be interested until the facts are placed before them. The Scripture reads, "How can they hear without a preacher, and how can they preach except they be sent." The Christian press is a powerful preacher. Clergymen do not read hospital journals to any extent. Very little hospital news ever reaches church papers, hence there has been a lack of information to the clergy and laity. The Protestant Hospital Association is now endeavoring to supply the need and demand for such information. We can do this best through the church press.

To show their appreciation some of the largest church papers have asked us for our articles; the one having the largest circulation in the middle-west has recently requested us to write a fifteen hundred word hospital article; others are writing us for stories illustrating the character of work done.

The educational programme is inclusive. We are trying to educate the public to use the hospital. When we remember that more than fifty million live outside the large centres; that fifty-six per cent. of the counties in the U.S. have no hospital provision—though Canada is better supplied with hospital and dispensary care in the larger provinces—and fully

three millions are sick and in bed daily; that twenty-eight per cent. of the sick, or 840,000, should have hospital care, with only a probable bed capacity at present of 460,000; that we have 400,000 crippled and deformed children: we are brought face to face with conditions requiring methods for healing and human reconstruction never yet employed.

We are therefore charged with the responsibility to awaken and create a Christian conscience for the healing of the sick. The people must be told what our hospitals are doing and what they are prepared to do for the sick; and special interest must be taken to provide healing for the poor and otherwise neglected.

One special purpose of our educational programme is to reach the sick and afflicted poor, living in remote places. Thousands who are sick or crippled do not know there is a possibility of being cured or improved. We want our 197,000 clergymen and ministers thoroughly informed of our hospital provision for the unfortunate; we want to co-operate with them in the commission "To heal the sick"; we are endeavoring to create a larger sympathy for God's afflicted children, and have included this as a definite part of our programme.

The Needs of the Hospital. Our educational programme includes the giving to the people a better understanding of the needs of the hospital. Through our publicity we have endeavored to promote the Kingdom of Heaven through local Christian hospital service. We find that as the community realizes its hospital is serving their sick and needy in a wholesome manner, the people are cheerfully giving of their substance to maintain it. We are trying to show them that our hospitals are actually giving this service; that our hospitals have needs; that unless the people respond to such needs the work of healing must be limited; and we are necessarily depending upon the public, the entire public, without regard to the particular religious preference, to help the local hospital.

There is no sectarian way of administering mercy. We are urging all churches and Christians to unite in each field in the hospital ministry of healing.

The Education and Training of Nurses has received special attention. We have sent a call for student nurses covering all America. We confidently expect all of the more than 7,000 hospitals of our country to share the benefit of this nation-wide effort to secure the required candidates for nursing.

But we are very anxious about the educational preparation and moral training of our nurse pupils. We are calling for the best girls to give their lives to this, the noblest of professions. Our Association is concerned about the moral and spiritual surroundings of these girls while in school. It cannot be denied that in many hospitals and nurses' schools the standards for deportment are not as high as they should be. All cigarette smoking, profanity, coarseness and irreverence should be stamped out. The Protestant Hospital Association has no higher mission than to inculcate the highest standards of Christian morals in its own and in all other hospitals.

Through our publicity and other methods of working we are emphasizing the spiritual needs of nurses while in training and after their training. Furthermore we are stressing the importance of a true missionary spirit versus a mercenary spirit.

We believe also that every hospital should render a spiritual ministry to its patients. It is a part of our programme to reach out into every state, county, municipal, and private hospital and training school, and extend the Church's spiritual ministry to all patients, nurses, internes and all connected therewith.

This is a stupendous task but we believe the Christian churches will stand with us and that by their aid we shall be equal to the task.

A World Programme. It may be a little too early to announce that we are looking to a world programme. Surely Christian America has responsibilities to the whole world. We need to train doctors and nurses with the spirit of sacrifice for our foreign hospitals, and we should not expect to escape the responsibility of doing our share to provide healing for the afflicted throughout the world.

Our Survey has discovered much Unoccupied Territory. We hope that the responsibility for these needy fields will be divided so that each church organization shall do its full share in making ample provision for the care of all sick. The call is loud for a close affiliation and co-operation of all denominational hospitals as well as the Christian workers in all hospitals.

There remains much to be done in the rural districts. They have never been adequately provided with medical healing and hospital facilities. We believe that all the churches within the horizon of a practicable working area should unite in establishing and maintaining an efficient hospital service. Here are great possibilities for the members of our Association.

Our hospitals and Christian management should not lose the opportunity, for they will suffer if they are left behind in the forward movement for hospital development.

It is the purpose of the Protestant Hospital Association to create a common bond and to quicken an interest among ourselves. Our united effort is a testimony of our faith. My office has made its strongest efforts to bring about these conditions the past year.

Our Association has accomplished much in the two years of its life. The first year we had one hundred members. We close the second year with a paid membership of one hundred and seventy. The past year I have sent out from my office 5,135 letters. We printed 4,000 copies of our Constitution and by-laws, also 4,000 copies of a pamphlet explaining the purpose and functions of this organization. Our personnel department is rendering constant service to institutions and executives in placing each in direct communication with the other. Our officers and trustees have served as advisers to many. In several instances weak institutions have been strengthened. Facts have been provided hospitals to aid them in their financial campaigns. In every possible manner we have sought to be co-operative with all other organizations. Our official relations with other hospital associations have been pleasant, and their official attitude toward us has been cordial.

In every respect we have sought to make our hospitals more efficient and their service more effective. We fully realize that we have problems all our own. The purpose of this convention is to discover our own needs and more perfectly to provide the remedy.

A careful study of our Constitution and Declarations makes it clear that we are operating in our own field, and in obedience to the Divine command to "heal the sick." Therefore, any subject connected with the work of these institutions is within our own province and entirely wholesome. We invite the co-operation of every protestant Christian worker and executive in any hospital, and particularly those connected with our church hospitals.

I want to thank those of you who have helped me place the facts before the people. We want every one enlisted in this work so that all the people may know the facts. We want them to know that we are promoting well organized and efficient hospitals; that we are endeavoring to conduct these under Christian management; that we will treat the unfortunate and sick to the extent of our limitations; that where our limitations end we invite them to assist and enlarge our facilities; that we look to a friendly public to provide the means of support so that none may be neglected; and that we purpose the finest Christian relations with all other bodies.

Assuring you of my confidence in our great undertaking, and the true mission we have outlined, I assert my purpose to do all within my power to promote the cause we have pledged ourselves to support.

FORMALLY OPEN NURSES' HOME IN HAMILTON

Under auspicious circumstances, the new Nurses' Home of the General Hospital was formally opened on October 18th, in the presence of many citizens. The building is the last word in modern construction, and nothing but praise was accorded the Board of Hospital Governors for their foresight in erecting such a fine home.

T. H. Pratt, who presided, as Chairman of the Hospital Board, said that criticism had been raised at what was felt to

be the high cost of the building. He recalled the opposition that was experienced by the Board before it succeeded in having the plans approved so that each nurse would have a room to herself. Those who passed through the home would be impressed, he believed, that the Board was not astray in insisting that the single room idea be carried out.

Col. Gartshore, Chairman of the London Board of Hospital Governors said the home was a revelation to him. London would soon commence construction of a new nurses' home for the General Hospital there, and he ventured the opinion that the Hamilton home would be copied from basement to roof. It was the finest nurses' residence he had ever seen, he said. Others who spoke were: Sir John M. Gibson, Dr. Douglas McIlwraith, Mayor Coppley and Dr. Walter Langrill, Medical Superintendent. The home has 109 single rooms and four double rooms. It also has a fine swimming pool, the halls are wide, and there are many cheerful living and recreation rooms.

THE DEFICITS OF TORONTO HOSPITALS

The hospitals of Toronto have been applying annually at the city hall for grants of money which will enable them to meet their deficits. Such grants are in addition to the per diem allowances from city and province—allowances which fall short of meeting the cost of maintaining public patients. The city auditor has now performed a valuable service in outlining a new set of bookkeeping conditions to which he considers the hospitals should conform in calculating the deficits the city is asked to meet. The effect would be to reduce the amount which the city is annually required to pay.

Mr. Scott would achieve this end in two ways: first, by limiting the type of deficit to which city hospital grants would be applicable; second, by applying to the reduction of these deficits certain subscriptions and bequests which are now set aside as an endowment.

Allowance for depreciation is the largest item which Mr. Scott would eliminate from the calculation of hospital deficits.

He would permit a replacement fund, being the amount expended to take care of repairs and current wear and tear in hospital equipment. But that is quite different from a fund, wherewith to replace hospital buildings and equipment when they become obsolescent or otherwise unfit for use many years from now. Mr. Scott says:

"If the city is willing to adopt the policy of meeting this charge for depreciation, the funds so handed over must be set to one side, and accumulated and used only for the construction of new buildings and equipment after those now in use have served their purpose."

If depreciation charges are to be included in the hospital deficits which the city is annually required to meet, the suggestion made by the auditor is a quite proper one. But it is not clear that the city should permit these charges at all. It is not clear that this generation of taxpayers should accumulate a fund to provide new hospital buildings at some future date. When these are needed, the taxpayers of that day may well be asked to contribute towards their erection. In dealing with the deficits claimed by the hospitals for 1921, Mr. Scott eliminated the amounts charged to depreciation. That is probably the wisest course.

The other issue of importance which Mr. Scott raises is the application of hospital donations to endowment fund, instead of to the reduction of current deficits. As to this he says that donations not specifically earmarked for endowment purposes by the contributors should be applied to current expenses. Again the auditor is right. But there will naturally be a systematic earmarking to endowment of such funds by the donors if the city insists upon deducting them from the deficits unless so earmarked.

Incidentally Mr. Scott points out two injustices to the Toronto taxpayer; first, that if he goes to a hospital as a private patient, he may be called upon to contribute more than he costs the hospital, the balance going towards the upkeep of public patients, to whose maintenance in the hospital the

same ratepayer contributes a second time in his taxes; second, the patients from municipalities outside Toronto are helping to create the deficits of Toronto hospitals, which deficits are then passed on to the Toronto taxpayer to meet. These are both important points, and should be discussed while the excellent report which Mr. Scott has made is under consideration.

OSLER ON FULL TIME SERVICE

Osler held that in any plan the hospital should form the unit or centre about which the general practitioners should unite. They were preparing for the change, and within a few years there should be a thoroughly practical working combination of the voluntary agencies with the state (Britain). The country hospitals—others, too—had already placed their services most generously for the work in tuberculosis, in syphilis, and in child welfare. To come into a national scheme there would have to be certain radical alterations in the arrangement of the staff. In many, the tuberculosis officer, the syphilis expert, the neurologists, the maternity doctor, the infant-welfare doctor had been recognized and special departments opened. The difficulty would be with medicine and surgery, if there were to be paid consultants attached to the hospitals. "Let me speak of medicine only," said Sir William, "as, nowadays, we can grow surgeons anywhere. Not so the modern physician, who has to be a man of much broader gauge, and is much harder to cultivate. Let us recognize frankly that in any new scheme there must be a reduction in the number of attending physicians. To grow a consultant. . . .take a physician of thirty or thereabouts, make him a half-time man with a good salary, give him 80 to 100 beds, with control of the out-patients and a staff of paid assistants. His job would be in the hospital from nine to one, seeing the special cases sent from neighboring doctors, making the ward visit and directing the work in the clinical laboratories. The afternoon would be occupied in private consultations and in country visits at fixed rates. What a godsend such a man would be in every county!"

One would suffice. Even under present circumstances such men exist; but we all know that pure medicine, as a study, has not of late been fostered in our county hospitals, some of which are still without the essential clinical laboratory. Such a man, too, would be in daily touch with the other departments—tuberculosis, syphilis, children. And one thing he would be expected to do—make the dispensary a living force in preventive medicine. He would be the centre of the social service work, which makes the out-patient department the strong arm of the hospital in its relation with the public. As that pioneer, Richard Cabot, says, the dispensary work is radical, fundamental, and preventive; and hits the problem of disease at three vital spots—rooting out foci in families or districts by following home the clues presented in the person of the patient, checking disease in its incipiency, and preventing chronic patients from relapsing into a discouraging and vegetative existence. The very best men in the country would be glad to make this their life-work; and in any national scheme I sincerely trust that the profession and the hospital authorities will deal with existing difficulties in a generous spirit.

BEAUPORT ASYLUM DAMAGED BY FIRE

Beauport Asylum, caught fire at an early hour on November 17th.

The flames broke out in the workshops behind the main building, and threatened the entire asylum. Fire fighters were immediately on hand, however, and the fire was under control without any panic among the inmates.

The damage is estimated as fifteen thousand dollars and is confined to the workshops.

PLAN NEW HOSPITAL

The Kitchener and Waterloo Hospital Board has decided to make 1923 a hospital year in the two towns, when it is hoped to raise the necessary money for the erection of a new modern hospital building. Plans for the new structure will be drawn up immediately as the accommodation in the present seventy-bed hospital is inadequate for the needs of Kitchener and Waterloo.

Book Reviews

Clinical Medicine, Tuesday Clinics at the Johns Hopkins Hospital, by Llewellys F. Barker, M.D., LL.D., Professor of Medicine, Emeritus, Johns Hopkins University; Visiting Physician to Johns Hopkins Hospital, Baltimore. Illustrated. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. 1922. Price, cloth, \$7.00 net.

It is with more than usual pleasure that we have been accorded the privilege of reading this volume from the pen of our esteemed collaborator, Dr. L. F. Barker, Professor of Medicine, Emeritus, at Johns Hopkins Hospital, Baltimore, Md. Dr. Barker's emigration from his native land to our good neighbors to the South, was a very distinct loss to Canada, but it was but a loan, as we hope he will ere long see his way to return to the fold and once again be a real Canuck. "Clinical Medicine" is a book of unusual interest to us. It is a splendid resume of what, to a vast army of students, became familiarly known as "Barker's Tuesday Clinics," at Johns Hopkins. Perhaps at few hospitals in the world has such a successful system of clinical teaching been carried on for years as at Johns Hopkins. When the reviewer was at college, it was his privilege to follow his teacher around the wards and listen to a didactic lecture on the different patients,

not being accorded the advantage of participating in any way in the physical examination of the case. At "The Tuesday Clinics," each and every student is his Teacher's assistant, the method of inculcating knowledge, being based on the idea that "the way to learn is to do." The clinics in this volume are essentially practical and visualize Barker's teaching splendidly. We believe that this book will be, as it should, an incentive to every hospital who so far have not enlisted each student as a clinical assistant, to do so from now on.

Modern Methods in Nursing, by Georgina J. Sanders, formerly Assistant Matron at Addenbrookes' Hospital, Cambridge, Eng.; formerly Superintendent of Nurses at the Polyclinic Hospital, Philadelphia, and at the Massachusetts General Hospital, Boston. Third edition, thoroughly revised. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. Price, \$3.00 net. 1922.

It must indeed be gratifying to any author to find it necessary to publish a third edition of a book in as short a time as the author of "Modern Methods in Nursing" has had to do. We congratulate Miss Sanders upon her new volume. It is a distinct advance upon the preceding edition and should find a ready sale.

The Causes of Heart Failure (Harvard Health Talks), by William Henry Robey, Assistant Professor of Medicine in Harvard University, Visiting Physician to the Boston City Hospital. The Harvard University Press, Cambridge, Mass. 1922. Price, \$1.00.

This little volume of forty-five pages is one of a series of Harvard Health Talks. It is a book which is quite safe when put into the hands of the general public. There is nothing in it that is new to a practitioner in medicine, but any practitioner delivering popular lectures would find this full of useful hints.

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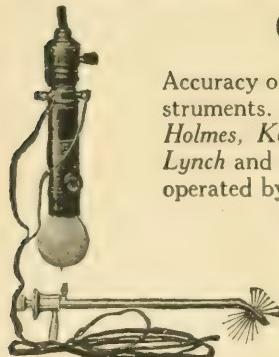
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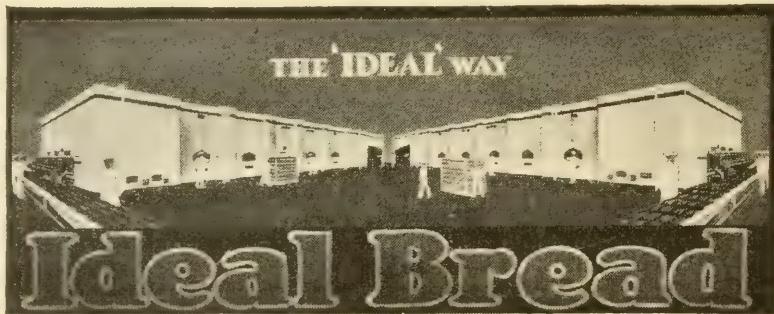
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Vol. XXIII

Toronto, February, 1923

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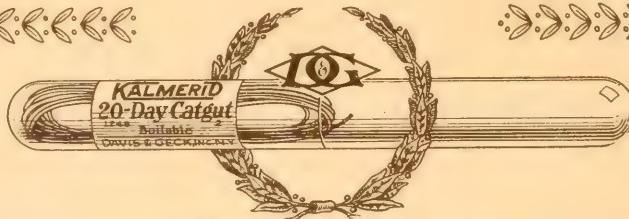
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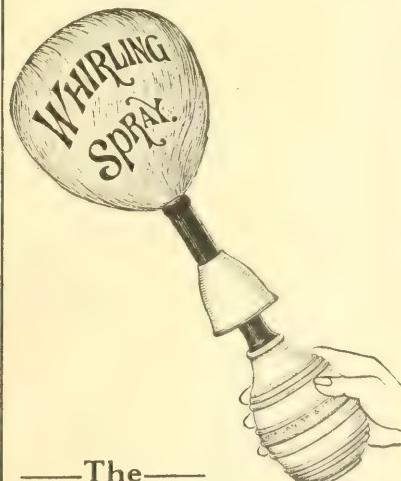
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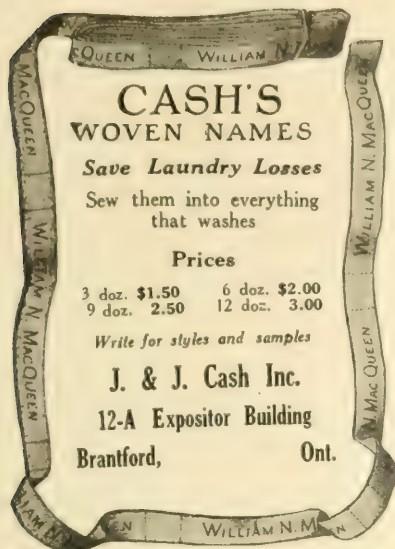
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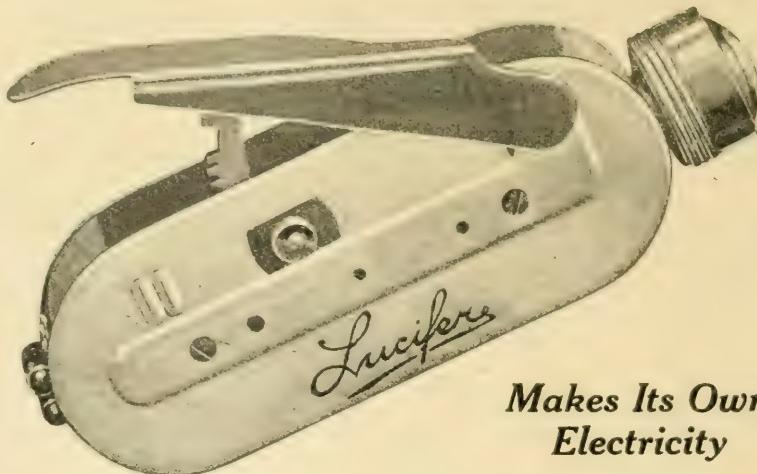
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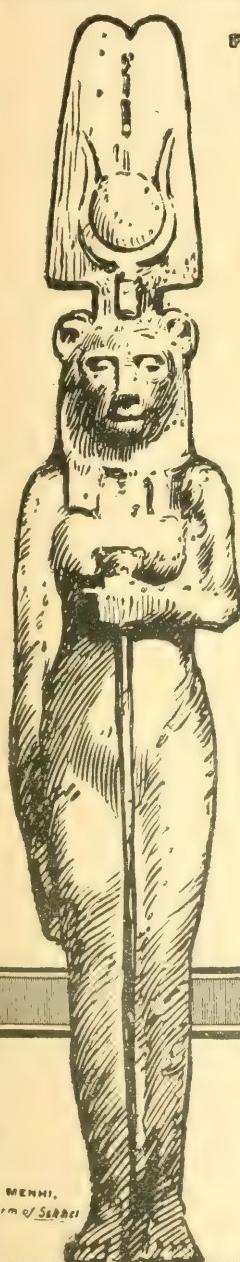
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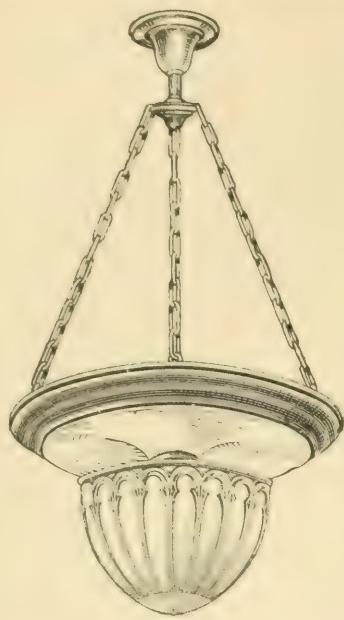
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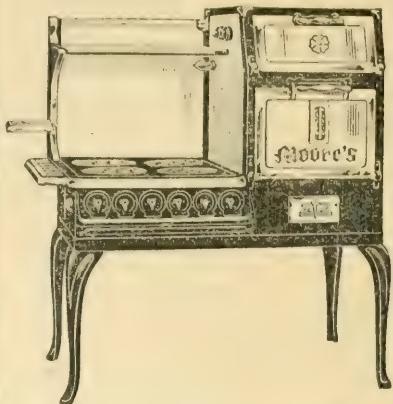
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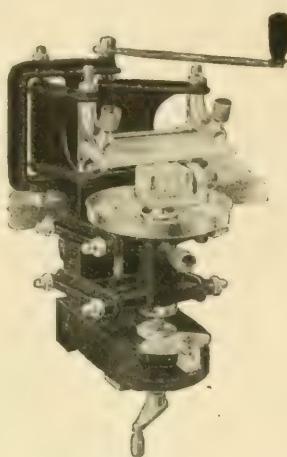
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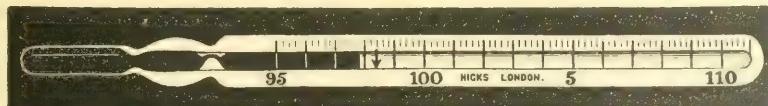
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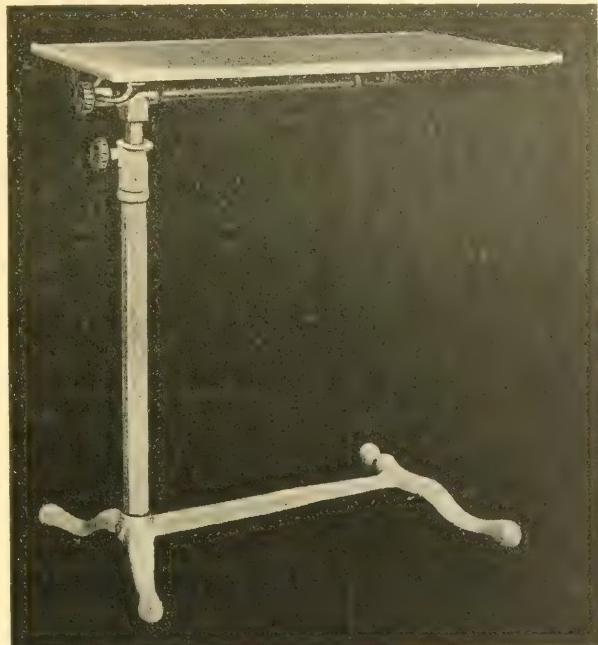
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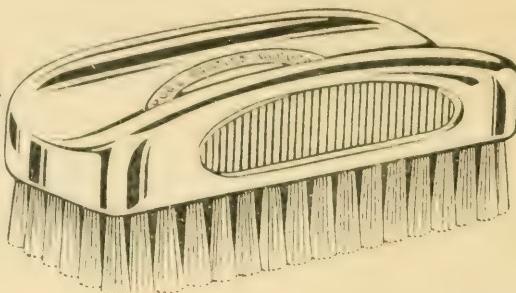
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The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire.

Vol. XXIII

TORONTO, FEBRUARY, 1923

No. 2

Editorial

Cancer

The profession has to thank the surgeons principally (we believe), for the introduction of Hospital Standardization and the establishment of Cancer Week. In this they do well, for the public and incidentally for themselves.

Too much stress cannot be laid on the early diagnosis of the cancer plague, which, according to most authorities, is much on the increase. Most authorities claim that the disease is not contagious and not hereditary, and most of them say that at first it is a purely local affair; opposed to this last statement is the contention of Bulkley that it is constitutional, and can be treated by diet and proper internal medication. The Medical Health Officer of Montreal quotes evidence to show that it is contagious: he calls attention to its great incidence in certain houses and certain streets of the city.

Opinions vary as to whether it is caused by micro-organisms. Some say yea, some nay.

Our knowledge of the disease is yet too nebulous for anyone to speak dogmatically. Both parties to all the above contentions may be right.

Gaylord, of Buffalo, says cancer is a multiform disease. If this be granted, then some may be purely local, and some constitutional; some may be caused by micro-organisms, others by certain systemic dyscrasias, trauma, or deficiency conditions. Some may be contagious—some not; some hereditary—others not.

Granting our ignorance on all the above points, we do know, or ought to know, certain things about cancer which should lead us to act, and that promptly and forcefully.

All ulcers, warts, moles, chronic inflammatory areas, scars and breast bruises, should be carefully scrutinized, palpated or otherwise investigated, treated and kept under continuous supervision, and at the proper time, if necessary, eradicated or destroyed by knife, radium or X-ray, as may be deemed best. If the general practitioner is in any doubt about the nature of any of these conditions he should speedily call for consultation with a specialist—skin, gynecological, surgical, or radiological.

Sunlight and other Lights

Much is being said and written about the therapeutic value of sunlight, ultra-violet rays, X-rays and the rays of radium. Rollier's work has been followed up by other experimenters, and there is no

question of the great value of prolonged exposure to sunlight over long periods, to patients suffering from bone and joint tuberculosis, tuberculosis of the skin, glands and lungs. The belief is held that the virtue of sunlight lies in its good effects on metabolism. Hess has proven that sunlight will cure rickets.

About a year ago this journal reported the great success of Harris, of Toronto, in bringing about cures of tuberculous spinal disease in some two dozen returned soldiers, treated by him at Christie Street Hospital, Toronto. The men wore plaster casts, but the sites of the lesions were exposed to the sun. The patients were kept at absolute rest, and, doubtless, were well fed. But Harris maintains, and doubtless rightly, that the sun was the principal agent in the cure.

Other workers are trying out the ultra-violet ray and finding it useful too, as a curative agent. Among its advantages over sunlight is that it can be given day or night and in any sort of weather, and without exposing the patient to cold, damp or frost; though we surmise the breathing of cold, pure air is a useful adjuvant to the sun cure.

Every thoughtful person can make a valuable deduction from all the above work: if sunlight works such wonderful cures, how important it is that all well people should expose themselves as much as possible to the sun's rays in order to prevent the inroads of tuberculosis, rickets, anemia and many other diseases which probably afflict them because of their lack of sunlight.

Impetus to Public Health Nursing

Since the war closed, 20,000 or more nurses on this continent have had to seek avenues of employment. The Red Cross has done much to make openings for these heroic women by planning for rural nursing. Over 1,300 nurses are so employed in the United States. We are pleased that an effort is being made in Canada to send well-trained all-round nurses into the country districts.

The public health nurse who goes out among farmers, lumbermen and the people generally, in the smaller towns and villages, needs to know much. She ought to be able to teach the folk how to handle a case of pulmonary tuberculosis, how to feed the baby, how to keep the premises sanitary, how to perform the simple nursing duties, such as feeding and bathing patients, and sterilizing, by boiling, utensils used by patients, and the like.

Her duties first commence in the school, and this requires special knowledge and training. By degrees she can insinuate herself into the homes of the children when she will find ample scope for her missionary zeal and tact. She will have to advise the pregnant mother, examine the child with diseased adenoids and tonsils or with heart disease or what not.

She must be strong and courageous for these duties. Transportation is often difficult. She will be exposed to inclement weather and will miss many of the comforts and conveniences of the city.

This job almost requires a super-woman to fill it adequately.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

The official organ of The Canadian Hospital Association, The Alberta Hospital Association and The British Columbia Hospital Association.

Editors:

ALEXANDER MacKAY, M.D., Inspector of Hospitals, Province of Ontario.

JOHN N. E. BROWN, M.B. (Tor.), Ex-Sec'y American and Canadian Hospital Associations. Former Supt. Toronto General and Detroit General Hospitals.

M. T. MacEACHERN, M.D., Director-General Victorian Order of Nurses, Ottawa. W. A. YOUNG, M.D., F.R.C.P. (London, Eng.), Toronto, Ont. Consultant, Toronto Hospital for Incurables. MAUDIE A. PERRY, B.S., Supervising Dietitian, Montreal General Hospital.

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Original Contribution

HOSPITALS AND THE COMMUNITY*

D. A. CRAIG, M.D., now Assoc. DIRECTOR AMERICAN COLLEGE OF SURGEONS, CHICAGO. (Late of HALIFAX, N. S.)

A good hospital is pointed out with pride by the citizens of any community. It is standing evidence of a most commendable public service which is seldom, if ever, questioned. The public hospital is an essential community investment, and returns on that investment are largely in terms of restored health for those citizens who have been so unfortunate as to have become ill. The restoration of health means the re-establishment of the working capacity of the individual; hence, the lessening of the economic loss to the community. The economic value of every person in any community can be recorded in terms of dollars and cents. We know what it costs to keep up our hospitals. Do we know on the other hand what is our economic return? What is the percentage working capacity of our patients on discharge from hospital? In other words, one might say what dividends in the way of restored health are our hospitals giving to the citizens of the community for their investment?

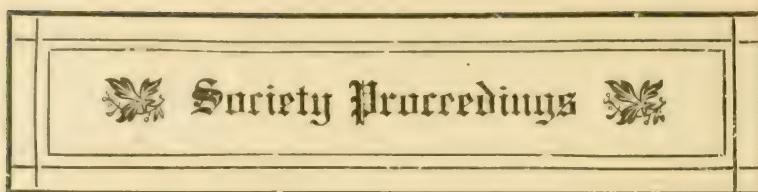
Hospital standardization means a better service to the patient, the advantages of a thorough and scientific investigation and treatment; hence, better returns to the community.

Standardization requires good case records, which are essential to every hospital. Our present day knowledge of scientific medicine is built upon records of the past. What we know of the old masters of medicine and surgery is given us from the records they have left behind them. We in our turn must provide the foundation for future development of scientific medicine by the careful observation and records of our cases. The fact is that our hospitals owe to future generations the records of their present experiences.

*Synopsis of talk given at Hospital Conference at London, Ont., October, 1922.

Besides the repair work in our hospitals, there is always the possibility of an educational function. There is an opportunity to make our hospitals centres for the emanation of health education. It is very questionable if many have realized this possibility. We utilize hospitals for the training of our nurses and medical students. Should we not also utilize them to some extent in teaching our people the simple rules of healthful living? In training medical students and nurses, we must insist upon the principles of thoroughness; consequently our hospitals must be thorough in their work and as efficient as it is possible to make them. In other words, we must practise what we preach. An institution which is simply a brick and mortar container for sick people is not in the true sense of the word a hospital. It may look like a hospital, and it may smell like a hospital, but it is not a hospital. Why are we here addressing you to-day? Because, after a careful study, we thoroughly and firmly believe that hospital standardization means better hospitals, more efficient medical and surgical service to our patients, better teaching facilities for our medical students and our nurses, and better community and public service.

We, of the medical profession, cannot hide behind a veil of mystery. Our gradually increasing standards of general education have developed in our people the spirit of inquiry after truth, and a demand for a most efficient service from our doctors, our hospitals and our nurses. It is up to us to render that efficient service if we are to fill our proper place in the community, and to maintain the confidence and support of our people.



CONJOINT CONVENTION, ALBERTA HOSPITAL ASSOCIATION AND ALBERTA ASSOCIATION OF REGISTERED NURSES

(Completed from last issue.)

MR. STICKNEY.—Did your contract holder have a voice in the election of your Board?

MR. COUSINS.—Yes, they have a voice in the election of the Municipal Board. They are hospital supporters.

MR. STICKNEY.—All the miners under contract?

MR. WILLIAMS.—Yes, but under special arrangement, made if they are living in the town of Drumheller. If not Drumheller men in the municipal district they have not that. It entitles them to vote.

MR. STICKNEY.—What is your opinion of election; is it preferable to appointment by municipal council?

MR. WILLIAMS.—I think the Hospital Board should be elected by the public at large, and I think their standing is much greater if they are answerable to the public and not to the municipal council. I think a Hospital Board is quite as important as a municipal council, because I have handled in a good many cases a good deal more money. They have problems that are much more intricate. I think that a municipal hospital Secretary-Treasurer has his hands full. I think when the hospital board is elected by the people the status is much firmer and much more thought of than if appointed by some individual council.

MR. COUSINS.—Don't you think that the tax is much too low to meet the needs of an efficient rural hospital?

MR. WILLIAMS.—I do not think so when you consider that fees are collected as well. I think if a member of their hospital, it certainly would be, but when you collect the hospital fee as well, the tax should be sufficient because, if you make it higher, it is really a burden, especially as levied on the assessment. Some men will pay \$15 and some \$2, and that is something we intend to get rectified if at all possible.

DR. HALL.—How about the \$1 a day, do they pay that very well?

MR. WILLIAMS.—We have very little trouble with ratepayers. I should judge that possibly three per cent. of the ratepayers could not straighten up their accounts on leaving. Sometimes we have to wait a while until the crops are assured, but I do not figure we lose one per cent. of our ratepayers' fees.

MR. HENRY.—How do you come out at the end of the year?

MR. WILLIAMS.—We find that our financial matters come out on the right side.

DR. STANLEY.—I think Mr. Williams has given us an excellent talk in his leadership of the round table conference, and no doubt has given some city representatives some insight into the administration as well as the difficulties of the municipal hospitals, which they have to face. We are glad to welcome to the Convention Mrs. Manson and Miss McPhedran, representatives of the Alberta Association of Registered Nurses and Dr. Baker of the Central Alberta Sanatorium, who will take a place on this afternoon's programme. Shall we proceed with the organization?

DR. HALL.—Last year I acted as Secretary of the Alberta Hospitals Association and I only took it over about six weeks before the Convention. This year I did not take such an active part, in fact very little part, but I would like to say that I have observed the need of more permanent organization with an active organization going on throughout the twelve months of the year, not an organization which gets busy about three or four weeks before Convention time, and many of us are probably not very familiar with the subjects and have not worked up properly our ideas, and have not fully gone into

the necessary means to gain the ends which we have set out to do. We must recognize in dealing with public health matters, that these matters have to be considered by the Department. Many come with little axes to grind, and have not worked the matter up for long enough beforehand, then we pass a number of resolutions which we have not time to get up in proper shape, and I think a step has been taken this time in the formation of a legislative committee to get definite resolutions. Last year the Department paid no attention to the resolutions passed by this organization. I would like to suggest in the Hospital Association two definite elements which have to be taken into consideration, the professional side, the nurses, and those dealing with the training of nurses. In the past the Convention has been divided into three sections, and those who have been asked to give talks and papers have been obliged to talk on the same subject before one organization and go the next day and give practically the same paper. I do not see why the professional side should be dealt with solely under the auspices of the Alberta Registered Nurses. We have in this Province around fifteen municipal hospitals, and besides the professional element in these hospitals we have the other element; similarly in the city hospital we have practically the same element to deal with. They are not so interested in the professional element, and where money has been spent, there have been certain influences which have tended to destroy this Alberta Hospital Association, and as I say, we have to recognize this group, this non-professional group who are vitally interested in the financial administrative and detail. Now, there has been an attempt, whether intentionally or because of misunderstanding, I do not know, but there has grown an idea with the municipal hospital administration, officials, secretary-treasurers and Boards of Directors that they are not wanted in the Alberta Hospital Association, or vice-versa, that these representatives, who are numerically much greater than the city members, do not want to meet in the Alberta Hospital Association with the city members. I have a letter here in

my pocket from a member of the Government service directly in control and he says: "I have made enquiries from my municipal hospitals and I do not find the officers are interested in the Hospital Convention to be held on the dates mentioned." I only want to say, ladies and gentlemen, that my personal opinion is that the members of the Boards and the secretary-treasurers of the municipal hospitals would gladly unite and be with us if we were properly organized as a Hospital Association. I do not believe the members of the municipal hospitals are antagonistic to the Alberta Hospitals Association. I believe their problems are exactly the same as ours, and the organization next year must be such that these gentlemen will be brought in and they will take a very active part.

MR. HENRY.—Cannot they come in now?

DR. HALL.—Right now there is an attempt being made to organize another Hospital Association.

MR. HENRY.—By whom?

DR. HALL.—Either by a group in the Government or the municipal hospitals.

DR. SMITH.—As Secretary of this Association, shortly after I was asked to assume the responsibility of this office, six or eight weeks ago I secured a list of the hospitals of this Province, municipal, city and otherwise, and I wrote to every hospital. I have received replies from almost every hospital in the Province, and no hospital from whom I received replies expressed any such ideas as Dr. Hall feels are prevalent. I may say I was delighted with the replies, and from the list we have here this morning that Dr. Stanley read, I feel we have a fairly good representation at this Convention. There are a lot of hospitals not represented. Some are not represented because of the fact that they did not feel they should spend the money to come in. One hospital is at Grand Prairie, another at Peace River, another at Athabasca Landing, and one at Fort McMurray, and then south to as far as Cardston, and they are scattered far and wide over this whole Province, and often cannot spend the money, and your Executive waited on the Department of Public Health and asked the Minister if it would be possible this year for him to be able

to pay the expenses from these hospitals in this Province. Mr. Reid took the matter very seriously into consideration and showed that he was interested in this proposition, but did not feel, for this year at least, that it would be possible for him to do that. Now another matter, seeing Dr. Hall raised this question, which is more serious than anything he has raised, and has more to do with the small attendance than anything else; while in session to-day there is another Convention being held in the city of Regina, and no doubt every hospital received notice of this Convention, which is being held in association with the Alberta and Saskatchewan divisions of the American College of Surgeons. This is unfortunate and I have not been able to find out how it came about that that organization should meet in Regina at the same time as this one, and I wrote at once to some of the authorities. Now I think that is a matter that we should get away from, and I hope next year, when the Alberta Hospital Association meets, the Alberta College of Surgeons for this Province will meet at the same time, and not attempt to divide this thing into two parts, Mr. Chairman. I feel as Mr. Williams said, that the problems of the smaller hospital are very similar to the larger hospital, and what we need is to go on with the organization we have and broaden out our work and take in and get hold of this section of the American College of Surgeons. Nothing has been said about standardization and very little has been said about the professional side of hospital work, and I think next year more emphasis should be laid on that.

PRESIDENT.—In regard to the attitude of the Department of Health I do not think there should be any misconception with regard to that. As far as the Minister of Health is concerned his sympathies are here, and there is absolutely no opposition coming from that quarter. The matter has been brought up through the Executive to find out if there is any hostility or action on the part of the officers of the Department to cause estrangement between the city and rural hospitals, and if there has been, it is the duty of the Association to inform the Minister of the matter, because I am certain of this, that the Minister would certainly take no part nor permit any official in his Department to do it, and such a letter as

this, it would be well to draw to the attention of the Minister himself. I am glad Dr. Hall has introduced it, as it has given us an opportunity of bringing into the open some of the things that have been gossiped around the halls, and next year we can undertake to bring together a larger and more representative body, but let me say this, I am not discouraged with the Convention. It has not been large in numbers, but I have known conventions twenty times as large that got nowhere and did very little compared with what we did here yesterday and to-day, and I am satisfied that the representatives we have had here discussing hospital matters have shown more intelligence, and come to conclusions that have more sanity, than in some larger conventions, and am safe in saying that a convention of this kind appeals to the Government, especially to a gentleman like Mr. Reid.

DR. HALL.—I can say in contradiction to Dr. Smith that the 15 municipal hospitals have plenty of funds, and there is not one could not have afforded to send a delegate, their head nurse, or their secretary-treasurer. It is not a question of funds whatsoever. I am quite certain of that, and I would like to ask Mr. Stickney to tell us just exactly what the difficulty is, as I believe he knows.

MR. STICKNEY.—That is a pretty large order. I agree with what Dr. Hall says with regard to the attitude of the municipal hospital to this convention. It is not lack of funds, but lack of interest. Last year, I think, was the first of these conventions I had the privilege to attend. The trouble with this convention as I see it was this. Most of the members of the Municipal Hospital Boards are farmers, and those not farmers are generally residents of the smaller towns or villages. We came up here last year, and no doubt it was the first time the majority had been here, and I am sure in the case of Drumheller we felt honored and gratified to receive the invitation. We came up and did not know exactly what we were coming to. It was quite different from any conventions we had been acquainted with. We could hardly see what benefit could be derived from it. Most conventions are rather informal, and they feel like expressing themselves and talking on any subject that come up, but last year we sat up in that hall. No doubt

it was all right, but you cannot get the viewpoint, you doctors and nurses, you cannot possibly get the viewpoint of the ordinary farmer. We meet farmers mostly and, as a rule, you will find they are not very good at mixing informally with other people. It takes a certain length of time to wear off that feeling of being a little out of place. We got up there in this hall with a lot of doctors and nurses, no doubt all good fellows, but we had the feeling that we were a little out of place, but there did not seem to be any part of the programme arranged for matters concerning municipals hospitals. Someone would read a paper, someone from Saskatchewan or British Columbia, a doctor or a nurse, and I am sure they were interesting papers, but they had very little to do with our problems, the problems connected with the municipal hospital. I consider this convention infinitely superior to the one last year, for as one fellow said "What do you know about this, did you ever see such a frost in your life, these fellows ain't human, we sure ran into something that time." I suppose that expresses the feeling of the delegates from the municipal hospitals better than anything else could. About this matter that Dr. Smith brought up about the Department being entirely in sympathy with this Association is right to a certain extent. I believe the Minister, if not influenced, is entirely interested, but I believe there is an influence at work in regard to this Association. One of the officials of the Department of Health expects to have a Convention of the municipal hospitals this winter and I do not believe that lack of funds will keep them away. Unless we can do something to counteract this influence in regard to this convention as far as the municipal hospitals are concerned, I am afraid we cannot figure on very much support or co-operation, and I am sure it is something to be deplored greatly, because as some gentleman previously remarked, the problems of the city and the small town are the same. The chief object, of course, is the care of the sick and, of course, there are other problems that take up more time and discussion than that, but the problems are the same, and I think a great deal could come out of this Association with the two different classes of hospital, or three if they can see it all alike, and get together and try

to work in harmony, so the different problems of the municipal hospital will be discussed here, and probably some of the things will be entirely clear to you people from the city hospital, for you have discussed them before and have dealt with them before, and I am free to admit, you will know more about it. I also feel that there would be a possibility that you ladies and gentlemen representing the city hospital might possibly receive suggestions from the delegates of the municipal hospitals that would be of value to you. I am sure you would not receive as much except, perhaps, on organization or along the lines of establishing a municipal hospital in your city which we need not consider at the present. I believe we can organize this thing so as to finally make it a success. My idea would be to have part of the Executive elected from the representatives of the municipal hospitals. This would relieve a certain amount of suspicion of the municipal hospital being against this Association if part of the executive were representing municipal hospitals, and of course you would need to get together and frame up some policy. I know farmers and everything connected with them, and you have got to appeal to them in the right way, and if you could show that only four of the municipal hospitals were represented this year, but that they were well enough satisfied for some of us to be on the executive, it would be a good thing for the hospitals in Alberta. My idea would be to have two different organizations, the municipal hospital under the care of part of the executive which consists of the municipal representatives, and have the secretary of the municipal part of it write each one of the hospitals and the small rural hospitals, a letter explaining our attitude, I think very much good could be derived from it, for we would have the advice of men who have been in this thing for years and years, and of course could show them that these men representing the city hospitals were only too glad and too anxious to have them come in as the larger the Association the more beneficial it would be. I am sorry if the Department, or anyone in the Department of Health uses any influence to split up this organization because it is entirely out of their province. The municipal hospital is locally controlled by Boards, and we have entirely the right to do what we wish as long as we have the funds, and I

think it is very advisable for some member to put the thing up to them just the way I have been putting it up to you here, showing the benefits to be derived from the larger organization instead of a narrow-minded attitude in forming a smaller organization.

PRESIDENT.—I would like to make the suggestion that we add Mr. Stickney's name to the Legislative Committee, and have him approach the Government along with the other members. I am quite sure with an exponent such as Mr. Stickney, you will be able to show the Honorable Mr. Reid the stand-point which we take.

Moved by Mr. Williams, seconded by Mr. Henry, that Mr. Stickney's name be added to the Legislative Committee. *Carried.*

MR. HENRY.—Just before you leave this point. It seems after hearing Mr. Stickney that there is some movement against this organization in the Department of Municipal Affairs or Health. I think it only fair to the Minister not to give it undue publicity, but to go to the Minister and have a heart to heart talk, and lay before him in an informal manner what we feel, but if an official of his Department is antagonistic to us, it is just as well to let the Minister know in company with that official, and I would suggest if the legislative committee does not do it that some other committee interview the Minister.

No motion recorded.

Seconded by Mr. Cousins, "That the legislative committee interview the Minister to-day at the earliest possible moment in regard to this matter or any other matters on which they wish to confer."

MR. WILLIAMS.—Might I move that this be a special committee, consisting of the President and Secretary. I think that the Legislative Committee will be meeting later on, and I think this matter calls for more or less urgent action, and a small committee would probably be better. Seconded by Mr. Cousins "That the incoming President and Secretary interview the Minister of Health." *Carried.*

Moved by Mr. Cousins, seconded by Mr. Dutton "That we proceed with the election of officers." *Carried.*

Honorary President.—Hon. R. G. Reid.

President.—Father Cameron.

Moved by Dr. Hall, seconded by Mr. Henry, that Mr. Stickney be Vice-President. *Carried.*

Moved by Dr. Hall that Mr. Williams be elected as Secretary-Treasurer. *Carried.*

Executive Committee.—Miss McLeod, High River; Dr. Smith, Royal Alexandra, Edmonton; Dr. Stanley, Calgary; Miss Edy, General Hospital, Calgary; E. E. Dutton, Galt Hospital, Lethbridge.

THE TRAINING SCHOOL FOR NURSES.

MISS FRANCES MACMILLAN.

As Superintendent of the Training School for Nurses in connection with the Royal Alexandra Hospital, I have much pleasure in being present at this, the first conference of the Alberta Hospitals, Alberta Medical and Alberta Registered Nurses' Associations.

The University of Alberta as an education centre makes a very fitting background for this gathering. The existence and presence of these very fine buildings represent the realization and appreciation of the need for higher education in this Province. Some person exclaims "Think of the cost." The uninitiated may reply "The student pays his way."

Approximately speaking, when it costs the student \$30 tuition per year in Arts, it costs the Province of Alberta some \$375 per year or, generally speaking, every Arts student owes the Province over \$300 per year for his education.

The medical student who pays more, as much more expensive equipment is required for him, owes to the Government around \$1,000 per year.

The student in Science and in the new Department of Agriculture will have as great a debt or greater to the Province.

But do we question the Government in this wise expenditure? The most conservative individual realizes that all greatness depends on education; the trained men and women graduating from our colleges pay back to the community life of the Province a thousand fold what has been expended on them.

Now education to-day comprises the welfare of the people generally, as emphasized so recently by the Hon. Perren Baker, Minister of Education, when he spoke of the four-fold standard of development in our school curriculum of to-day—the physical, the mental, the spiritual, and the service side of life.

This four-fold standard is and has been the fundamental feature in every Training School for Nurses.

To this understanding audience there is no need to explain the strenuous life of the nurse-in-training, the great strain put upon her physical well-being, the need for a keen mind to assimilate the theoretical part of her daily lectures after a hard day's work on the ward.

Glimpses of her spiritual self shine through infinite patience in the most exacting situation, and she gives service to all with whom she comes in contact in the Nursing School, and later to the community at large.

The lay person to-day is prone to consider that our hospitals exist but to care for the sick, when we who are in close touch with hospital life know that they exist as well for the education of our medical students and pupil nurses.

A college graduate who had recently applied for admission to a Training School was asked why so few college women had similar plans. The answer was "Too few hospitals seemed to offer their students a reasonable home life with normal opportunities for relaxation and recreation." Speaking for Alberta, I fear this is but too true—yet we do not complain of our various Hospital Boards. We feel that at heart they consider nothing too good for the pupils under their care. However, the matter of finance is a large question. Hospitals are not self-supporting, and the sick must receive their first attention.

A patient requires around 133 cu. ft. of air space in order to live under healthy conditions, yet some pupil nurses in Alberta are permitted to rest, study, sleep and keep most of their personal belongings in less than half that space.

I am afraid some of our living quarters would hardly stand the inspection of a Public Health Office, and yet at the completion of their training our pupils are asked to go out to teach public health in various parts of the Province. To-day, 27 of these are employed by our Provincial Government.

We expect that our pupils be not only physically fit, but that they be super-women radiating enthusiasm for their patient as well as themselves—and to be ever ready to answer to our S.O.S. call "Service," as often as is necessary.

As educationists we are agreed that we must safeguard the health of our people in this our Province of Alberta. As the confines of our Province extend we must be able to develop our hospitals and increase our supply of rural nurses, if we can hope to do our part in the Provincial scheme of affairs. We must have sufficient nurses—our output of trained nurses must meet the demand of the settlers in the most remote districts as well as of those in the urban centres.

To this end, I would ask this organization in convention to approach the Provincial Government of Alberta to consider, when making out their estimates for the year 1923, to be as liberal as possible in providing a grant to the Training Schools for Nurses in the Province.

I have no hesitancy in making this request because we all know the interest that this Government has devoted during their short tenure of office towards improving the educational conditions in Alberta.

PRESIDENT.—I think that paper is quite provocative of discussion.

MISS MCPHEDRAN.—It has always been a source of mystery to me why such a very important educational branch should be neglected to the extent it is. I am afraid we sometimes get the idea that the student nurses in the hospitals are there for service only. When she leaves the hospital there is the education of the public in health matters, and no one in the whole community is better able to teach the public at large on health matters as the nurses are, but if the educational part of their training is neglected then it reacts on the public at large.

Miss McLEOD.—I think if we paid a little more attention to the housing of the pupil nurse and recreation, we would get a higher standard of women entering the nursing force, and if we could get the co-operation of the Government to give us a grant we would benefit as a professional body.

DR. SMITH.—The Provincial Government as we are all aware, makes quite a liberal grant to all public schools throughout the Province, so much per teacher, so much per room, and I think in the technical school it is higher. So far they have never seen fit to do anything for the training school for nurses. As a matter of fact I believe our Government considers that the grant they make to the hospital of 50 cents per patient per day really covers this obligation. Now, as a matter of fact it does not do so for this reason: they make the same grant to all hospitals whether they have training schools or not. Now it has also been said by some that the hospital that has a Training School for Nurses really receives from the undergraduate as she goes through her course the kind of service which repays the hospital for any extra expense in having a school there, but when you come to actual figures, the figures are rather startling. Last spring in connection with the Royal Alexandra graduating exercises, I took occasion to look particularly into this question, and I gathered a considerable amount of data on just how much it cost us to operate the Training School, putting a value on the services of the undergraduate nurses as they went through the hospital and putting a price also on her board and room and that sort of thing, also putting a value on the time of the nurses who trained these pupil nurses. Now, we found out at our hospital that the graduating class of twenty nurses cost us over and above anything, they rendered the hospital \$1,000 per nurse. In other words, by the time a class of twenty nurses got through the hospital they were indebted to the hospital to approximately \$20,000. Now I have met several nurses who are interested in this work in training young ladies in the nursing profession and had them go over this question and so far these figures have not been contradicted. Several heads of training schools that I have spoken to have been surprised when they came to figure out just the amount of time given to the training of the

undergraduates. Now from the moment they come in, these nurses have to be watched and followed around for fear that they will do something that will do more harm than good. They do not know anything about hospital work, and for days their working service is of no value to the hospital for they have to be watched.

DR. STANLEY.—The point has already been made, and I think it is well worth while emphasizing, that the nurse is not simply for service she may render in nursing the sick directly, but apart from that she has a very important duty to perform in many instances. The point should be emphasized that she is a teacher. We must have training schools in our Province that are going to give information and instruction and training to young ladies who are going to act as teachers for nurses yet to come, and these nurses are being taken by the Public Health Department of our Province and are being used for teaching the public. Now that is a thing that seems to be overlooked by the general public, the value of the training school in educating our nurses to be used in public health work by the Department of Public Health. Those in charge of Training Schools should see and insist that those who are taken on as probationers should have sufficient preliminary training to make them students in the Training School, and it should be emphasized as a policy on the part of our Government that a standard should be set for preliminary education; particularly would I urge it in regard to the term "R.N." I believe that the preliminary standard should be sufficiently high to ensure that a nurse who will come to receive university training should have a sufficiently high academic training to ensure she will be able to take a position that a degree of that kind warrants her to take.

ADDRESS.

By HONORABLE R. G. REID, Minister of Health.

I am glad that the Chairman has mentioned the fact that I am a very busy man because it will prepare you for the extreme brevity of the speech I am going to make to you to-day. I do not have any great message for you. I wish to welcome you

here to-day and trust that your deliberations here will be profitable, that you will go home benefited by the discussions, and that the discussions which you will have will also be profitable to the Province as a whole.

I like to hear the remark which Dr. Smith made about the Public Health nurses. I am proud of these Public Health nurses; in fact Dr. Smith expressed a good deal of my own thought in connection with them. I always think these girls going out doing this work are preaching the evangel of good health, and before many years we will see the fruit of their work in a concrete way.

Now in connection with the problems and the questions you are most intimately connected with, and for that reason most interested in, hospital work, I have a little to say.

There are so many things enter into the successful operation of a hospital. You, in your discussion which has just been closed, I believe have been dealing with the necessity of a higher standard in your training schools. In addition to that, of course, we all know that we depend more or less on the medical men, but there is one thing more considered and mentioned than all, and that is the financing of that hospital. We see so frequently throughout the Province, hospitals doing splendid work for a time and then they get into difficulties and probably their usefulness is gradually or absolutely done away with. I am interested in two ways; I am interested to see the hospitals in as high a state of efficiency as it is possible to bring them, and for that reason alone I am anxious to see them on a strong stable financial basis, because we find when hospitals get into financial difficulties they immediately apply to the Government. Prior to the time I accepted office we had a special department of the Health Department which was known as the Municipal Hospital Branch. I found there was no such thing as a Hospitals Branch. We had paid attention to the municipal hospital, but there was no branch particularly devoting attention to hospitals other than municipal. I made a little change and we instituted a new policy, and in connection with the institution of that policy, and to show you how we poor mortals are always misunderstood, some good

friends immediately jumped to the conclusion that I was ascribing powers to myself and going to interfere with the management of hospitals unduly. No such thought was in my mind any more than placing expert advice and experience at the disposal of any hospital who wished to apply for that assistance. I thought when I made that change that it would fill a real want, and the experience of one year has shown that was the case absolutely. I am not going to recite the history but simply instance one case. There was one hospital in Red Deer, and I am quite frank to admit before I start to tell you, it was an outstanding case, and probably in all the time of the administration of the new branch they will not have a case to equal it again, but we found when we went there, at the request of the City Council, that they had accumulated a deficit of \$8,000 in one year's operation. For an institution of that size you would think they had been sitting up nights to see how they could manage to make it, but undoubtedly that was the deficit they accumulated that year. After investigation, a report submitted and that report having been acted upon, now having four months under the new conditions we find a saving has been effected in that time of over \$4,000. Now if we can save at the rate of \$1,000 a month in that small institution, then I believe there is some justification in the action I took in making the Municipal Hospital Department a Hospitals Department.

Now before I conclude I would just like to say this to you, that the betterment of our conditions in hospitals and otherwise is going to be brought about, not by the Government, not by the Nurses' Association working on their own initiative, not by the individual working here or there, but is going to be brought about by the bringing of these forces together, working in a close, harmonious way, with the one objective in view of making this Province not only an outstanding Province in health matters, but a pattern to the whole world.

Moved and seconded that a vote of thanks be extended to the Honorable Minister. *Carried.*

RELATIONSHIP BETWEEN THE CENTRAL
ALBERTA SANATORIUM AND THE
OTHER HOSPITALS OF
THE PROVINCE.

By DR. BAKER.

Mr Chairman, Ladies and Gentlemen: I must apologise first because the short paper I have prepared is not absolutely along the lines which the programme states. It was originally prepared for the Alberta Medical Association, then Dr. Smith got after me and said it had to be given here, so it is not absolutely according to the title on the programme. I propose to make a few remarks on T.B. sanatorium work.

SOME PHASES OF TUBERCULOSIS SANATORIUM WORK.

It is significant that there are meeting in this city to-day, associations of physicians, nurses and hospitals. All are bent on the relief of suffering and the prevention of disease. With these forces co-operating and taking the public into their confidence, as regards health and disease in so far as this is practicable, we can enthusiastically look forward to definite progress in health matters resulting from this spreading of available information. A little learning is a dangerous thing, and right now there are signs that intensive instruction in questions of health and disease is needed if we are to prevent unfortunate disasters which follow in the wake of wrong and insufficient information and of immature decisions.

The rapid disappearance of typhoid fever in epidemic form has not been accomplished by any specific remedy. The widespread knowledge of the nature of this disease and of its control has lead to the practical enforcement of such habits of living, involving the expenditure of millions of dollars for a clean water supply and for proper sewage disposal, that already typhoid fever is the exception where formerly it was the rule. Similarly we have no specific for tuberculosis, but by broadcasting what is now known of this disease, it is to be expected that public opinion will demand such practical measures, involving the expenditure of money, as will tend to reduce the morbidity and mortality of the Great White Plague.

And even in this supposedly healthy country there is room for improvement. Upon the basis of the Framingham Health Experiment, approximately one per cent of our population is suffering from active tuberculosis, and an equal number from arrested disease. Ferguson has recently reported on 1,346 representative public school children in Saskatchewan, that 56.6% showed signs of previous infection; slightly less than one per cent. of the 1,184 white children had active tuberculosis and needed treatment, and 2.5% of the white children showed signs and symptoms more or less suspicious of activity. I am informed that in this Province there are 123,328 white public school children, and on the basis of the Saskatchewan report we may assume that among these there are 1,035 active cases of tuberculosis and 3,083 very-suspicious cases.

What is the place of the Sanatorium in the anti-tuberculosis movement? Its primary importance lies in its value as an educational influence in health matters, particularly of tuberculosis. A practical daily demonstration is given to patients in the ordinary sanitary requirements of houses as regards heat, ventilation and light. Patients soon discover that their feeling of well-being are increased by hygienic living, and definitely diminished if the latter be neglected. This leads to frequent inquiries as to how the individual home can be so arranged to afford the best possible living conditions. Emphasis is laid on the fact that cleanliness of person, clothes and living quarters is essential. Without it contagion, sickness, suffering and death are bound to increase.

There are many cases where a real cure is not to be expected and it is important to show these people how they can continue to live and still be useful. There are certain activities in which they may engage, there are others which must be avoided if a feeling of well-being is to be maintained. Great time is not required to convince the average person, that safety first lies in a rational, balanced life as regards food, rest, work and play. But to develop the habit of so living may require longer. The desired state where a patient can keep his expenditure of energy within the limits of his supply can be attained, but to maintain this under modern living conditions requires considerable experience and foresight.

One sees so many, who, both before being admitted for treatment and also during residence, can maintain a moderate degree of health, but who persist in such expenditure of energy as to prevent any real cure or satisfactory arrest of the disease. Many of these fail, I believe, through lack of proper instructions and of persistent observation to keep them going well. In addition to the personal interest and help given to patients by members of the staff, there is a good influence of other patients, and many who might otherwise fail in their effort to get well, are carried along by the massed institutional will to get well. It is easier to take the cure where that is the daily custom, than where one plays the lone game among healthy people, who are apt to encourage too much, or censor too severely.

Definite training is necessary in methods to prevent spread of infection. "Learn to do by doing" is a safe principle. Suitable pressure is required to develop careful habits in many. Some people constantly study themselves so that they may be of no danger to others, while there are those who require compulsion. The former class can safely be treated almost anywhere, while the latter class will be a dangerous source of infection unless constantly watched, which is impossible unless in an institution or under the direct care of a trained attendant whether professional nurse or other.

The medical staff in addition to frequent individual instruction has, through periodic talks to groups of patients an opportunity of spreading needed information. Suitable subjects are the facts of infection, the reason for treatment, the proper routine for home life, the symptoms of an approaching relapse of the disease, the evidences of possible early attacks of T.B. among friends, the advantages of periodic examination and observation of people most likely to become victims of this disease, and other health matters.

The results of such educational work are that nearly every patient becomes more intelligent, reasonable and conscientious in his or her endeavor to get well and to be as useful as possible. I am sure that a patient well informed on tuberculosis, conscious of the nature of his disease, is a greater asset to his community than the same person unaware of the fact

that he suffers from a communicable, costly disease, and ignorant of the many facts that all so handicapped should know, as thoroughly as they do the three R's. This patient carries into his home, into the community, the leaven of knowledge regarding tuberculosis and respiratory diseases, which will continue to work until the whole of our population has the pertinent facts regarding this disease. And when this day arrives public opinion will insist on the expenditure of money in preventing disease, as a profitable investment.

Every discussion of sanatorium usefulness would be very incomplete, if mention were not made of the desirability of giving to the nurses-in-training experience in tuberculosis work by having them serve a few months in sanatoria. While this is being carried on comprehensive lectures on tuberculosis—the common disease—should be given. The graduate nurse comes into such intimate association with the general public, that her opportunities for spreading useful and accurate information of disease are unparalleled—and likewise because of her position of confidence, she can do much harm, nor can we entirely blame the nurse for the fostering of myths and fancies, if through our training schools and sanatoria we fail to give the latest and best instruction.

We are proud of the fact that a Western Sanatorium, i.e., that of Manitoba, through the influence of Dr. Stewart, has been the first to give a definite course of training in tuberculosis to medical students. Through mutual arrangements the university and the sanatorium have been able to give the Manitoba medical students several weeks' residence in the sanatorium for intensive study.

The medical care of the sick is not to be minimized. This is a distinct phase of sanatorium work in contrast with the educational. Favorable cases diagnosed early and given proper treatment, can be put well on the road to recovery, provided they have the intellect to grasp the requirements of the road to health and the normal stamina to live up to these day by day. Others who enter the sanatorium only when they no longer can work, or when they can no longer take care of themselves, need scarcely hope for more than improvement and a delay in the progress of this disease. Both of these

groups profit wonderfully through thorough education in the laws of this disease and in methods of withstanding it. The apparently hopeless and terminal cases need, and should have the best of care and every small attention, which can be given them, so that their unfortunate condition can be made as easy as possible. Frequently the comforts of hospital or sanatorium life surpass those found in the homes of this country. Nor does the benefit of institutional treatment of these hopeless cases rest solely with the patient, but extends in a more far-reaching and essential way to the community at large in reducing the opportunities for exposure of the healthy to massive contact in the homes. As a public question, the state can scarcely afford to have the infants and children, daily exposed as they are bound to be in homes with advanced cases.

The sanatorium should function as a centre for diagnosis of respiratory diseases. To this end it should be equipped with every known aid in diagnosis, and staffed with those capable of giving the public the advantage of everything known in this branch of medical science. Those cases requiring special study, or those who have not facilities near them for special examinations, can enter the institution for such a period as is necessary to determine the presence or absence of clinical tuberculosis. Many citizens have easy access to hospitals, and to physicians for this period of observation, but there are many in this Province not so favorably situated, and to them especially the sanatorium can offer help. The sooner our hospitals and sanatoria become more definitely centres for diagnosis, as well as for treatment, the greater service will they render the public. I am convinced that more stress should be laid on the desirability of periodic examinations of those specially liable to develop this disease, and of those clinically inactive. It is the prevention of the disease as a clinical manifestation, that we must work for, and not the ultimate elimination of all infection. I have mentioned only three phases of sanatorium work, the educational, the care of the sick, and the diagnostic. There are others which it is not my purpose to deal with here.

These aims will be realized, according as patients from all parts of the Province and from all classes of the community can be reached and instructed, and then returned to their homes to

have greater or less influence. If this educational work, so briefly mentioned, be worth the expenditure of money involved in sanatorium treatment, we need as patients, all that can be accommodated, and preferably those not in the hopeless or terminal class. It is the early case, or at least the one just diagnosed, which has on the one hand the greatest life expectancy, and therefore the most helpful influence on the community, or on the other hand the greatest life expectancy and therefore the greatest possibility of spreading this disease provided he is not well trained and thoroughly watched. From all standpoints if training be advisable, the early case is the profitable one.

It is quite true that nearly all cases recover from their first attack, and that others have periods of remission from symptoms whether being treated at home or in a sanatorium, but, are the facilities in the homes such that the patient is forced to learn how to take care of himself and how to protect others? From what I have seen I fear they are not. One frequently hears a patient who has had this disease for several years express regret, that he had not known at the beginning of the fight, what he had learned when hope of great improvement was gone. Tuberculosis is probably the most curable of all chronic diseases. Proper treatment aims to cure, but still is amply justified if it can prevent the train of suffering and disaster which follow the steady progress of this disease. The desirable length of time for sanatorium treatment varies with the individual and his home environment, and even if a sufficient time for satisfactory subsidence of symptoms cannot be afforded, a few weeks properly spent will result in the broadcasting of useful information.

One frequently hears it stated, both by patients and others, that their disease is not far enough advanced to make sanatorium treatment advisable. This is a wrong impression, provided we believe that such treatment is ever indicated. There is no doubt that the time to treat any chronic disease is at its very first manifestations. One may not want treatment, but that in no way minimizes the fact that he needs it, nor lessens the benefit which the State derives from his having it. To the man who has just been diagnosed as tuberculous, and who

hesitates to take treatment because he does not feel sick and weak, we should say: "Now is the accepted time and now is the day of salvation."

DR. SMITH.—I would like to introduce to you Dr. Hepburn of the Medical Association who has come to bring greetings from that Association.

DR. HEPBURN.—Mr. Chairman, Ladies and Gentlemen. I have just had this honor thrust upon me. This, I believe is the first occasion when the three organizations have combined to hold their annual meeting at one time. Now probably the arrangement this time has not been perfect. I have no doubt we will find as time goes on that we might have arranged our programme to better advantage. However, it requires experience and in drafting the medical programme I was a little at sea as to what would really interest the hospital people. There was a time when the medical men did not consider the hospital people, when the medical profession considered themselves the important people, and the hospital authorities and nurses were side issues. However, it is very different now and things have taken a change and greater prominence is being given, greater publicity is being given hospital work. The general public is now taking an interest in hospitals and nursing matters and we found that during the last year several times the question came up not of how people in the outlying districts could receive attention from a doctor but how they could receive nursing, and hospital accommodation which rather indicates that the public is being educated to the proper proportion, the proper relation of the medical man to the hospital and the hospital to the medical practitioner, so I hope in future we will be able to arrange our programmes so that there will be no confliction and probably we will be able to attend more of the meetings of the Hospital Association and the Association of Registered Nurses and probably some of our meetings might be of interest to you people. I think the lecture I have just come from, given by Dr. B—— Professor of Surgery in McGill University would have appealed to the nurses and lay men, and I have no doubt in future the meetings can be arranged so they can be attended by the representatives and the members of the different organizations.

I do not wish to keep you any longer but just to say that it is the wish of the Medical Association that this arrangement should continue and we may develop it to our mutual benefit.

FATHER CAMERON.—I can assure you, doctor, that you have struck a reciprocal chord in our hearts and the representatives will give fitting response to the words of greeting you have brought from the Medical Association.

Vote of thanks to Miss Hunt, moved by Mr. Cousins, seconded by Miss McPhedran.

DR. SMITH:—There is a matter I would like to take up. It has been customary I believe, ever since the Alberta Hospital Association was organized, to have a report of the proceedings, including the papers presented, and the discussions and resolutions, and all that, printed in a special publication, and then distributed to the various members of the association. This has been done at considerable cost. I have not the exact figures here, but I believe last year the cost was three or four hundred, and one year it ran as high as six or seven hundred. Now just recently I had a communication from Dr. Brown, in Toronto, who is editor, I believe, of the *Hospital World*, which is the Canadian hospital publication. It occurred to me we might be able to make arrangements with that magazine, for them to publish all papers presented, together with resolutions and reports, discussions and that sort of thing, if we forwarded this material to that magazine. This could not naturally all be put in one paper, but will be spread over probably six or eight publications. It would not cost the hospital association anything at all, and most hospitals do take this magazine, and those who do not probably may be induced to do so. The subscription is a matter of three or four dollars a year, and it would relieve us of this heavy financial burden. To that end I would like to move

“That the Executive Committee be instructed to have all papers, reports and resolutions published in the *Hospital World*, instead of making a special publication which would involve the expenditure of three or four hundred dollars.”

DR. LAFFERTY:—I have much pleasure in seconding that motion.

PRESIDENT:—I do not know that there could be any objection, except on the part of those who are good enough to prepare papers for the meeting. I do not know whether they wish to copyright them or not.

DR. SMITH:—I had a communication from Dr. Brown in which he wanted a report of this convention. Instead of writing him a report I would send him the whole thing. The Secretary is not here just now, but I think it is customary for the retiring secretary, to get these matters cleaned up. *Resolution carried.*

DR. SMITH:—I would like to move, “That all the resolutions which have been referred to the special legislative committee be submitted to the Alberta Medical Association, now in convention, and the Alberta Association of registered nurses for their endorsement.” I am sure these two associations would back us up in these resolutions.

DR. LAFFERTY:—I believe the college of surgeons and physicians will be very glad to co-operate in this movement and I would include their name in this resolution. *Carried.*

EVENING SESSION: PUBLIC MEETING.

CHAIRMAN: FATHER CAMERON.

Ladies and Gentlemen:

I regret very much that we have not the Lieutenant Governor with us to preside at this meeting, because the Lieutenant Governor is always so fine; he is an old medical man himself, and is interested, and the meetings of the medical profession always appeal to him very deeply. . . . In a way I feel highly honored to preside at this meeting tonight, because it is the first time in the province of Alberta we have had the three organizations of public health, the medical association, the hospital association and the nursing profession all united together to discuss their common and interlocking problems. That in itself would make this an

auspicious occasion, but when we think that, in the domain of public health, Alberta leads not only all the provinces of the rest of this fair Dominion, but is a leader of great parts of the world in public health utilities, I consider it is an exceptional honor to preside here to-night. We have with us to-night the Minister; we have the president of the medical association, the president of the hospital association and we are to receive addresses from them. We also have with us the supreme magistrate of the city, representing mayor Duggan, who has come to-night to bid us welcome—Mr. Bury. I asked Dr. Smith how I should introduce him, whether Free State or Republican, but he said he had not diagnosed his case yet.

MR. BURY:—Now, the official reason why I am here to-night is because the mayor is not. I do not mean "Is not" in a Biblical sense; I mean he is not here officially. He is not here, because he has gone to Ottawa, to make what preparation he could, so that the citizens of Edmonton during the coming winter, who might otherwise find themselves without work, can have something provided. That is the official reason for his not being here. Since I have had to discharge the duties which appertain to his office, if it were not that I did not wish to speak evil of dignitaries I would be inclined to think, though officially gone to get employment for other people, he went to escape employment for himself. However, since I have to take his place, it naturally lies on me to do what I think he would do. I know he would pour a libation before the altar of convention, by expressing his pleasure that the convention had been able to hold its gatherings in the city. . . . I wish to express on behalf of the citizens and the council and the absent mayor, the gratification we have, that you have been able to hold meetings in this city. . . . and we want to express to you, gathered here, the hope that your convention gatherings and meetings will be a source of pleasure to those of you who have come up from points outside of Edmonton, not merely pleasure in the immediate associations and gatherings of the convention but that source of sweeter pleasure, which comes from distance of memory, as the Scotch put it, of the experiences

which you have had here in Edmonton; and our hope is not only that you will enjoy yourself, but that the gatherings of the convention shall be full of profit alternating with pleasure.

Some of you come from far distances and your lot is largely cast in solitude and you experience in your own spirits the monotonous, paralyzing drudgery of maintaining the routine of the professional service and you long occasionally for the greater development and more active life of your brothers and sisters practising the profession in Edmonton. To those of you who come from such scenes as these, such gatherings must be an inspiration, a source of new ideas, a source of stronger aspirations to do the service that belongs to your noble profession. . . . Health is no longer a private matter but a public concern, and all public concerns occupy the minds of public men, and there is no matter with which they are more vitally concerned than the matter of public health. There is no matter in which the Minister, in which Parliament have a right to take an interest or a more imperative duty, to do what they can than in the domain of public health. . . . Now there is one other thing I would like to say before I close, and it is this; that I am glad to be here because these conventions are held in this University and the time is not far distant when this University will be in a position to contribute to the health service, the medical service of this Province that to which it is properly fitted to contribute. The medical service will send out, to serve men and women, men trained in medical and surgical science and every other department connected with sanitation and health. I think if the heart of the President of this institution were opened we would find traced there the strongest aspiration that the medical building which has been erected in these grounds, shall be a medical school which will render it unnecessary for any parent in Alberta to send down his child to get his education in the east or any of the older universities of Europe or the Old Country, but that this university shall meet all the medical and health needs of the Province.

PRESIDENT.—On behalf of the Association I wish to thank the Acting Mayor for his remarks of welcome, and I am sure that we who come from the quiet cities of the south should enjoy ourselves in this fine city.

Vocal solo, Miss L. Hunt.

Paper: Everyday Pediatrics, Dr. F. W. Stockton, Calgary.

ADDRESS: HON. R. G. REID, Minister of Health.

Mr. Chairman, Ladies and Gentlemen :—

There is one regret I have in connection with this series of meetings and that is that I cannot be present at every one for they are dealing with subjects I have always been interested in, and now that they are within my reach I find the pressure of public duties does not allow me to take advantage of them.

There is something responsible for this gathering. What is it that causes it? This enthusiasm on the part of individuals from different parts of the Province, enthusiasm for the cause, enthusiasm for their duty, and while that enthusiasm exists and is manifest in this way I think that the future, the outlook for the care of health conditions in this Province is distinctly good, for I feel always and at all times that the problems of public health are, with all problems of education, for the people, to be educated up to the point where they realize the necessity for better health conditions; then it is public health conditions will automatically materialize. The politicians usually set out to make good fellows of themselves and to make themselves the most popular. Still to-night we have two lengthy speeches before us, so I think I will not endanger my popularity. I have nothing further to say except repeat the happy sentiments expressed by the Acting Mayor. On behalf of the Province I feel it my duty to welcome you here—it is a pleasant duty—and to wish you all success in your endeavors and wish that you will go back to your homes feeling you have profited by the experience, and feeling you have added something to this important public health which we are all striving to build up.

The meeting closed with the singing of the National Anthem.

Canadian Hospitals

NEW ISOLATION HOSPITAL, EDMONTON, ALBERTA

For several months the question of choosing a site for the new Isolation Hospital in Edmonton has been under discussion, and at a meeting of the Edmonton Hospital Board, a month ago, it was definitely decided to recommend that it be erected on lands adjacent to the present site of the Royal Alexandra Hospital, which is a general hospital of two hundred and seventy beds. The Edmonton City Council has approved of this location and it is expected that the work of construction will commence in the early spring.

At the last meeting of the Edmonton Hospital Board, held November 24th, a special committee *re* New Isolation presented the following recommendations:

(1) That the new hospital be of the block type, three storeys high—

- (a) Because it would be more in harmony with the present buildings on this site;
- (b) The block type is very much more economical to operate than the other;
- (c) The block type, from a scientific standpoint, has been proven to be satisfactory;
- (d) That the block type is more economical to erect, providing both were estimated as modern fire-proof buildings.

(2) That this building be of modern fire-proof construction.

(3) That it be erected north of the present administration building, parallel with 112 Ave., and about seventy-five feet south of the south side of 112 Ave.

(4) That each floor of this hospital be in two sections of eighteen beds each:

- (a) Each section to have two wards of six beds each.
- (b) Six observation wards.
- (c) Each six-bed ward to have a toilet, wash up basin for doctors and slop sink.

- (d) Each single or observation room to have wash basin and also slop sink.
- (e) Each section to have the following: small serving kitchen, linen room, nurses' room, doctors' room, clothes chute, baths, small utility room for cleaning utensils, discharge room and balcony.
- (f) The basement to be three or four feet below ground level and laid out to make provision for receiving rooms, X-ray, small emergency dressing room, sleeping quarters for help, dining room for help, dining room for nurses while on duty, main linen room, entrance to clothes chute, entrance to dumb waiter, store room.

The New Isolation Hospital building to share in common with the present hospital:

- (1) One central refrigeration plant.
- (2) One central main kitchen.
- (3) One central laundry—to be erected entirely above ground level, so as to insure adequate and proper ventilation for employees while on duty.
- (4) One central heating plant.
- (5) One central nurses' home—the present nurses' home to be enlarged so as to provide:—(a) sixty additional single bedrooms; (b) dining-room, 1,600 square feet of floor space.

THE TORONTO PREVENTORIUM

"The Daughters of the Empire in Toronto may well be proud of their magnificent work in connection with the Preventorium," declared Mrs. John Bruce, Treasurer, at the tenth annual meeting of the I.O.D.E. Preventorium, held in the Board Room on November 30th. As represented in actual dollars and cents, the scope of the Preventorium's activities had increased in an unusually satisfactory manner. At the end of the fiscal year, closing on September 30, 1922, the total worth of land, building and equipment assets, endowment fund and balance from the maintenance fund, stood at the enormous sum of \$252,708.

During the past year a sum of \$14,722 was paid to Mr. A. E. Gooderham, thus completing repayment of his loan of \$27,000 used to purchase a nurses' residence. Small honorariums, amounting to \$600, had been given to the young doctors who had so kindly assisted the institution with their services.

Among the interesting items in the maintenance expenditures were: Meat, \$994; butter and eggs, \$1,457; flour, bread and meal, \$750; milk, \$1,127, and drugs, \$256. Total maintenance was \$52,112, with total absolute expenditure of \$10,408.

Dr. Harold Parsons, in his report as medical adviser, stated that 214 children had been treated during the year. On September 30, 1921, there were seventy-five children in residence; in the following twelve months 139 had been admitted and 142 discharged, leaving a present enrolment of seventy-two. The average period of residence was 128.6 days. All the children had been exposed to tuberculosis contact and many were more or less infected. In most cases the home conditions of the children were far from desirable. As an illustration, Dr. Parsons told of one family where the mother had just been sent to the Weston Sanatorium, leaving six children, all under ten years, and all infected.

One child had gained twenty pounds in six months; another twenty-two pounds in nine months and still another six and a-half pounds in four weeks.

Dr. Dixon had joined the medical staff, to take charge of the skin disease cases. Dental treatment was given by the Department of Public Health of Toronto, and Dr. C. K. Clarke had made a mental survey of the children. Dr. G. A. Davis, who has charge of the babies' wing, reported forty-seven admissions, with only one death during the year. As to the general improvement of the children during their stay in the Preventorium, there could be absolutely no question, he said. Dr. Elliott also spoke briefly, referring to the continent-wide fame of the institution.

Miss Fraser, in her report as Superintendent, stated that it was the aim of the Preventorium to give every child all possible benefits through the extension of the work, yet without losing the personal touch. A new laundry, costing \$7,000, had been a much-appreciated addition to the equipment.

Officers for the ensuing year are: President, Mrs. E. F. B. Johnston; Vice-Presidents, Mrs. W. R. Riddell and Mrs. John D. Hay; Recording-Secretary, Mrs. A. E. Gooderham, Jr.; Treasurer, Mrs. John Bruce.

Victorian Nurses' 25 Years' Service in Splendid Work

The auditorium of Gage Institute was packed on November 28th for the lecture given by Dr. M. T. MacEachern, Director-General of the Victorian Order of Nurses, who told of his survey of Canada from coast to coast for the purpose of studying the conditions under which the Victorian Order is working and of making recommendations for an extension of its activities and a strengthening of its influence all through the land.

The speaker, who was introduced by the Chairman, Hon. W. A. Charlton, stated that there was nothing but success ahead of the order, that it stood for service, co-operation, co-ordination and efficiency, and that its representatives were beloved by the people wherever they worked.

The Victorian Order, declared Dr. MacEachern, desires that its status be understood; that it does not wish to usurp, oppose or in any way interfere with other organizations, but will co-operate fully with all other agencies working in the interest of health, whether they be voluntary, State or municipal. All health organizations, he said, must get together, shoulder to shoulder and hand in hand, so that there may be a clear-cut, whole-covering policy for Canada. He recommended a local health agency in every community, a Provincial Health Council with a representative from every local agency, and a Dominion Health Council with a representative on it for each Province.

The Victorian Order, he explained, has grown fifty times in size since its inception, and the work is eleven times greater than finances at head office can provide for. There are in Canada 400 nurses belonging to the Victorian Order. This last year they ministered to 60,000 people and made 600,000 visits.

By means of lantern slides the speaker showed the multiplicity of ways in which the nurse serves. Not only is she found in the lonely sick room, giving bedside care, but she holds clinics, gives health talks to children, conducts classes in mothercraft, imparts pre-natal advice, watches over babies during their first year of life, and gives generous social service to needy families. Some of the slides illustrated rather eloquently the value of the nurse to the foreign immigrants who scatter through the Western Province and settle far from centres of civilization.

The Order, the speaker averred, had been much too secretive during its twenty-five years of service. Its duty is to tell the public of its activities. Everything connected with the order should be extended, and more supervisors and organizers are required in the field. The rural districts particularly need nurses, and there lies their greatest opportunity.

The speaker expressed the hope that the day might never come when voluntary and philanthropic effort would give way to State aid. The ideal condition is Government, municipal, philanthropic and voluntary agencies functioning together in the best interests of the public weal.

A NIGHT FIRE PATROL

The destruction of St. Boniface College, Winnipeg, by a night fire, with the loss of ten lives, mostly students, is only one of many of a like kind spread over the last forty years or more in Canada, in asylums, jails, poorhouses, schools, hotels, factories, or business blocks used as dormitories or living quarters.

Reckless talk about arson, or bigotry, has followed some of these fires and losses of life; but the almost invariable attendant fact is that there was not a single person awake in the building to raise alarm when the fire occurred, or even a fire alarm system installed to awaken the inmates when the heat rises above the safety point. Let there be less talk of incendiaryism as a cloak of what is criminal neglect on the part of someone.

And there are scores of these fire-traps in use all over our country as soon as winter sets in. What is still worse, many of these semi-public institutions employ showy or dangerous architecture: mansard roofs, domes, wooden columns to look like stone. Even fireproof construction is not to be depended upon without patrol.

One man, even a woman, to patrol the institution during the night on a time-recording system—better still, in connection with a local fire system, is the only security. And this patrol can do some work as well.

Our Provincial Legislature should investigate and frame up protective laws, and the provinces of still colder climates ought to be even more active. No public building of twenty inmates without a fire guard should be allowed to carry on. And a stricter building law, at least for all semi-public institutions, should be enacted and enforced.

FERGUS WELCOMES PRINCELY OFFER

The offer of Dr. S. Groves to dedicate to the town of Fergus, as a free gift, the finely equipped Royal Alexandra Hospital, which he founded and has conducted with conspicuous success, will be submitted to the ratepayers at a public meeting to be called by the City Council. The generous offer has been greeted with enthusiasm.

Speaking of the gift the *Fergus News-Record* says: "What is without a doubt the greatest gift ever offered to Fergus, or, for that matter, to any place outside of our largest cities, was made to Fergus Council, when Dr. Groves, the Medical Superintendent of the Royal Alexandra Hospital, here, magnanimously offered to deed to the town this building and complete equipment, worth, at the lowest estimate, some \$50,000, without the payment of one cent therefor.

"Dr. Groves has been a medical practitioner in Fergus, his home town, for over half a century. He has won for himself a widespread reputation as a surgeon, equalled by few in the Province. Some twenty-two years ago he decided, for

the benefit of mankind, to open up a hospital here. Many thought a hospital in a small town could not succeed. But Dr. Groves put his indomitable energy and skill into the venture, and, as a result, the Royal Alexandra Hospital was established, and to-day takes a place excelled by none of its size anywhere.

"During this time about 9,000 patients have passed through the hospital, the death rate being exceedingly low. Over 100 nurses have graduated here, and many fill most important positions in hospitals throughout the Continent."

ASK \$125,000 GRANT TO ADD TO HOSPITAL

President Ambrose Kent, E. J. Lennox, Col. Noel Marshall, W. A. Baird and Dr. Edmund King, of the Board of the Hospital for Incurables, Dunn Avenue, Toronto, asked the Board of Control, recently, to recommend a grant of \$125,000 to assist them in erecting an addition to cost \$250,000, to accommodate from 125 to 130 patients.

Mr. Kent said that when the hospital applied for a grant of \$50,000 on building account twelve years ago, they agreed to take care of at least fifty city patients. "Since then," he added, "the city has grown almost double and the demand for our institution has grown, and to-day we have not a building to cope with the demands made on this hospital. We have to-day, on orders given by the medical officer of health, 170 patients and we undertook to pay for fifty. We have over thirty waiting for admission. It is impossible for us to take them."

The deputation said that they hoped to get the Government to assist the hospital. Eighty per cent. of the patients, some bedridden for years, seventeen being cancer cases, came from the city.

The application was referred to the City Hospitals' Commission for a report.

HAILEYBURY TOWN WILL HAVE HOSPITAL

Through the co-operation of the I.O.D.E. and the Ontario Red Cross Society the fire-stricken town of Haileybury will be immediately provided with hospital service, under the Permanent Hospital Building and Site Committee. By a Dominion-wide contribution the I.O.D.E. has raised funds to purchase a desirable property in Haileybury, on the lake shore, with a house suitable for equipment as a ten or twelve-bed hospital.

Immediately after the fire of October 4th, which burned to the ground the existing hospital, the Ontario Red Cross offered to Haileybury a ten-bed emergency hospital unit, to be equipped and operated by the Red Cross until such time as permanent arrangements could be made by the town. Through the action of the I.O.D.E., Haileybury is enabled to accept the offer of the Red Cross Society, and it is hoped that the hospital will be opened at an early date.

Mayor LeHeup, of Haileybury, recently visited Toronto to meet representatives of the I.O.D.E. and Red Cross, and expressed the cordial appreciation of the citizens of Haileybury for this co-operative effort on their behalf.

"ANCRUM BRAE" PARTIALLY DESTROYED BY FIRE OF UNKNOWN ORIGIN

Fire from an unknown source partially destroyed "Anrum Brae" private hospital at Stratford on December 3rd, entailing thousands of dollars' damage. The blaze, which started in the attic, was discovered about 10.15, and had evidently been burning for a considerable time. Fortunately only two patients were in the institution, and they were carried to safety and later removed to the General Hospital.

While the firemen fought the flames, willing assistants succeeded in getting most of the contents of the downstairs rooms to places of safety.

The fact that the nearest hydrant is almost half a mile away from the burning building caused some delay, but, despite this handicap, the firemen succeeded in confining the flames to the attic. The second story and ground floor were badly gutted by water.

The institution was purchased only a few months ago by Dr. Steele, of Tavistock, and had just been thoroughly renovated.

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One Telfer Arrowroot Biscuit is equivalent to
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Four shades are available, plain brown, green, terra cotta and grey. Various grades are available to suit every requirement, ranging from the British Admiralty standard six millimetres (one-quarter inches) to a lighter grade of about two millimetres. To obtain satisfactory results the manufacturers recommend the engaging of expert laying service. This is supplied by many floor covering merchants, who, for a nominal charge, lay this covering according to detailed specifications, thereby ensuring permanent, satisfactory results.

A HOSPITAL WAGON.

A fully equipped hospital wagon, drawn by four mules, is the conveyance used by Dr. Charles B. Kobert, director of the bureau of trachoma and prevention of blindness of the state board of health, for his six months' trip through western Kentucky. Dr. Kobert, who started on his trip early in June, will give free treatment to all persons suffering from eye diseases. On the trip made in the summer of 1921, Dr. Kobert operated in eastern Kentucky on more than 4,000 patients having trachoma. Congress has made an appropriation of \$200,000 for a new trachoma hospital at Pikeville.

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THE DAILY BATH.

"If every one took a daily bath, hot or cold," Sir James Crichton Brown says in the *R. and C. Medical Pocket Quarterly*, "tuberculosis would virtually disappear from the world." Commenting on this article a writer in *Clinical Medicine* says he would legislate the great unwashed out of existence by having a tub in every home.

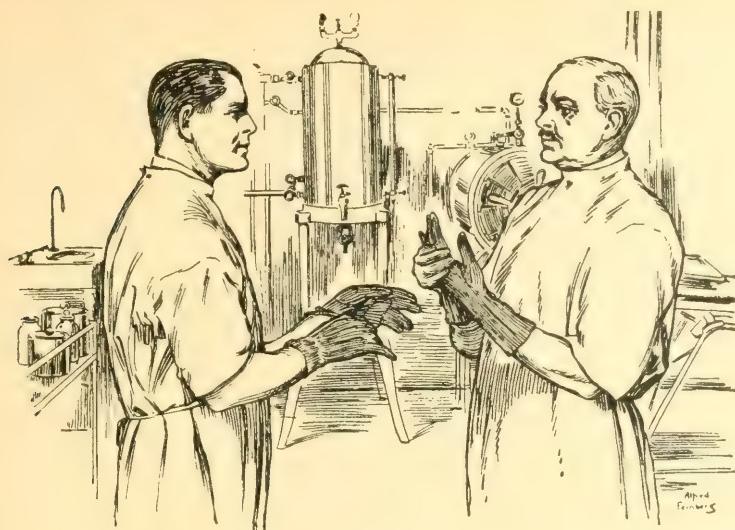
The *Quarterly* adds that there is much in the suggestion, for there are still people who do not know the value, not to say the joy of a daily scrub. Physicians could dispel such beliefs if they would, but perhaps they fear to insult their patients even when they know the advice is needed.

If Sir James thinks that he could legislate the great unwashed out of existence (or, in other words, to convert them into the great washed) by having a tub in every home, he should commune with some settlement workers or social workers who visited certain tenement houses in which bath tubs had been supplied with the benevolent intention of taking the "un" out of the unwashed. To their surprise, they found that the bath tubs formed very convenient receptacles for the storage of potatoes, cabbages and other provisions. In other families, the tubs served more closely their actual purpose, being used for soaking the family washing; but, as to washing the family—that was something else again.

There is no manner of doubt that much good would follow if everyone took a daily bath. This habit seems to have a beneficial influence far beyond that of assuring at least reasonable cleanness of the body. It has a moral effect. It leads to a desire for being generally well groomed. It engenders a distaste for soiled clothing and for preventable dirt and slovenliness in general. Of course, there are some occupations that are unavoidably dirty. But, in that case, we are dealing with "honest" dirt which is legitimate when gotten rid of promptly as soon as the worker comes home. There is no doubt about it but that it gives us a comforting, even luxurious, feeling to have gotten rid of the "foreign matter" on our bodies and to have donned clean clothing.

\$40,000 FOR HOSPITAL

By the will of William Scott, Egmondville, Ont., the town of Seaforth is left \$40,000 for the erection and maintenance of a hospital. Further sums of \$2,000 each are left to Clinton, Goderich and Wingham hospitals. The estate amounted to about \$90,000.



DR. JUNIOR: "Doctor, would you employ Antiphlogistine in severe cases—women, for instance—of abdominal pain, indicating possible ovaritis, peritonitis, salpyngitis, and so on?"

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DR. JUNIOR: "Well, I did that same thing, last night, and it was gratefully received by the patient. But—I had not studied 'Gynecology' that way—"

DR. SENIOR: "No, you felt, perhaps, that this was so simple a procedure that your prestige as a modern physician might be questioned—I know—I was once young and wished to appear 'ultra-scientific.'"

DR. JUNIOR: "Presume you're right. But—the patient says this morning, that she has had such attacks often, and never got out so easily or so quickly."

DR. SENIOR: "Such a procedure—that of applying Antiphlogistine to the abdomen in all incipient inflammations of that region, is as truly scientific as an operation, and sometimes makes that unnecessary. But its osmotic action, accompanied by initial heat (and generating its own 'chemical' heat, as we know it does), Antiphlogistine frequently aborts abdominal inflammations with speedy recovery and untold comfort to the sufferer."

DR. JUNIOR: "Really, Doctor—I believe Antiphlogistine has won me a friend, in this very instance."

IT IS TO SMILE.

(From the *Glasgow Herald*).

The celebrated London practitioner, Dr. Abernethy, of whom so many stories are told, used to say that he only once encountered a really sensible woman, with whom he had the following consultation regarding an injured hand:

Abernethy—Bruise?

Patient—Bite.

Abernethy—Dog?

Patient—Cat.

As all the original stories of the world are said to number three, this may have been the origin of Phil May's celebrated cartoon showing the interior of a chemist's shop, the chemist, and a battered female customer.

Chemist (to customer, whose face is covered with bruises and scratches)—"The cat, I suppose?"

Battered female—"No, another lady!"

KIWANIANS OFFER AUTOS TO MOVE PATIENTS

The Kiwanis Club, Toronto has found an outlet for the activities of its busy members. Recently, framed notices were sent to the following hospitals: Grace, St. Michael's, Wellesley, Western, General, Sick Children's and Christie Street, to the effect that any patients requiring to be removed from the hospitals and unable to afford a car, will be taken care of by the Kiwanis Automobile Committee, free of charge.

This work seems to be meeting with whole-hearted approval from all members of the club.

As soon as propitious weather again sets in, the weekly drives will no doubt be resumed, but in the meantime, the Automobile Committee finds no scarcity of worthy channels through which to steer its course.

GOVERNMENT GRANTS TO HOSPITALS

The decision to make the distribution of the Government grant to the hospitals conditional upon the raising of an equal amount of new money has met with almost universal disapprobation among those interested in hospitals. The Ministry of Health, however, has taken a very firm stand in the matter, and the cogency of the arguments in the letter which Sir Alfred Mond contributed to *The Times* a month ago cannot be gainsaid.

Many Chronic Cases Require Institutional Care

The advantages of institutional treatment for stomach and intestinal disorders, Neurasthenia, Heart Disease, Diabetes, Obesity, Nephritis, Rheumatism and other stubborn chronic maladies are worthy of consideration.

A most important advantage is the isolation of the patient from harmful influences, substituting conditions and surroundings that are altogether recuperative and reconstructive. To have the patient constantly under observation for the necessary period of time, is greatly to the advantage of the attending physician.

At Battle Creek, every case receives, first of all, a careful examination. Each patient is submitted to the X-ray and all other up-to-date methods of investigation, including chemical and serological examinations of the blood, efficiency tests of the liver, kidneys and other vital organs, tests for acidosis, metabolism tests and other special tests and researches which may be required to throw light upon the individual case.

The diet is carefully supervised by the physicians, and each patient is placed under the care of a thoroughly trained dietitian who sees that every dietary indication is thoroughly met. Special attention is given to changing the intestinal flora, thus suppressing intestinal putrefactions. There is no "course" of treatment; no routine methods are followed. Each patient's prescription is based upon his individual requirements.

At regular and suitable daily periods, corrective gymnastic classes are conducted by expert physical directors, and here again strict attention is given to the individual needs, as indicated by the physical examination, which includes a "strength test" of the whole body.

Another Battle Creek feature which is especially appreciated by the intelligent patient is the opportunity for educating and training in health habits by means of which he may, with the supervision of his family physician, maintain a high standard of health and efficiency after having been restored to health.

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A VALUABLE PRESCRIPTION

In the practice of medicine, physicians are consulted daily by patients who have no organic disease, but are sufferers from various types of functional disorders that are exceedingly difficult to handle and even more difficult to cure. How many business men of to-day, through nervous strain or overwork, become neurasthenics, are poor sleepers, have headache, inability to concentrate for any length of time, and are often inclined to exaggerate their symptoms and worry their doctor. Such cases, as medical men well know, have not to be confined to bed, but, on the other hand, require to remain away from the office, have perfect freedom from worry and enjoy a good night's sleep. One of the principal difficulties in such a case is to have them occupy their time pleasantly and be prevented from worrying and inclined to go back to business before they are sufficiently well. One of the best prescriptions for such a patient is *a weekly visit to the Allen Theatre.*

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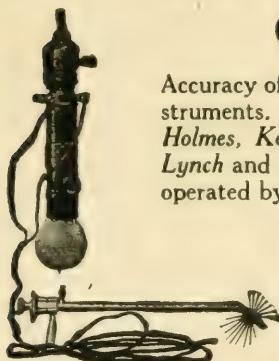
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THE HOSPITAL WORLD

Vol. XXIII

Toronto, March, 1923

No. 3

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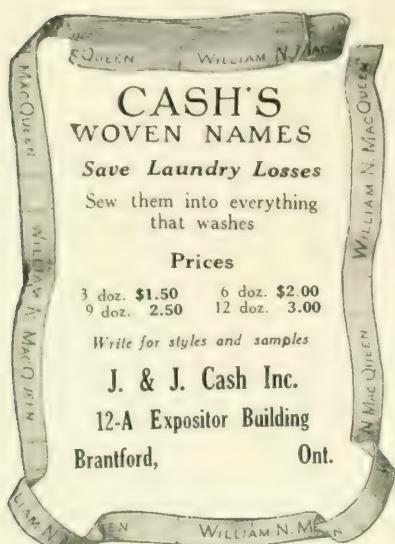
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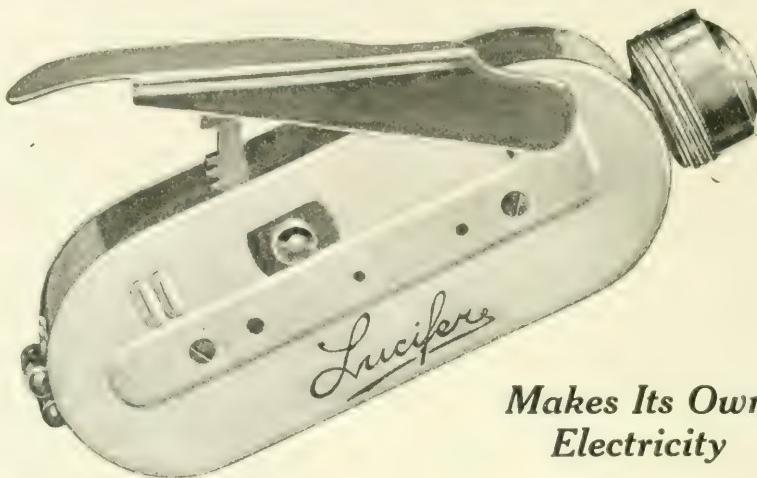
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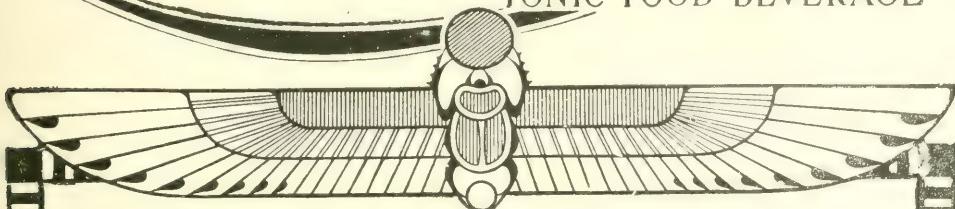
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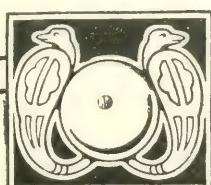
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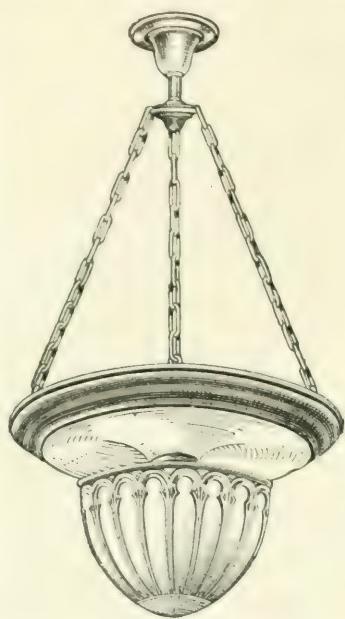
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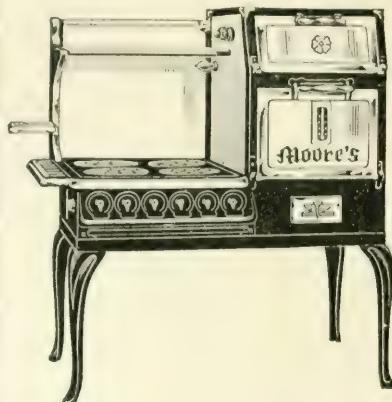
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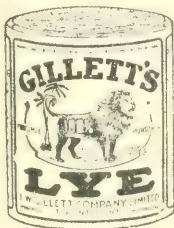
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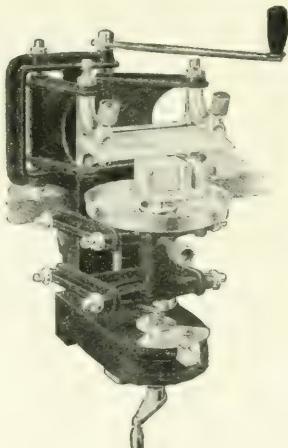
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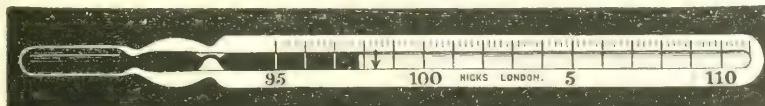
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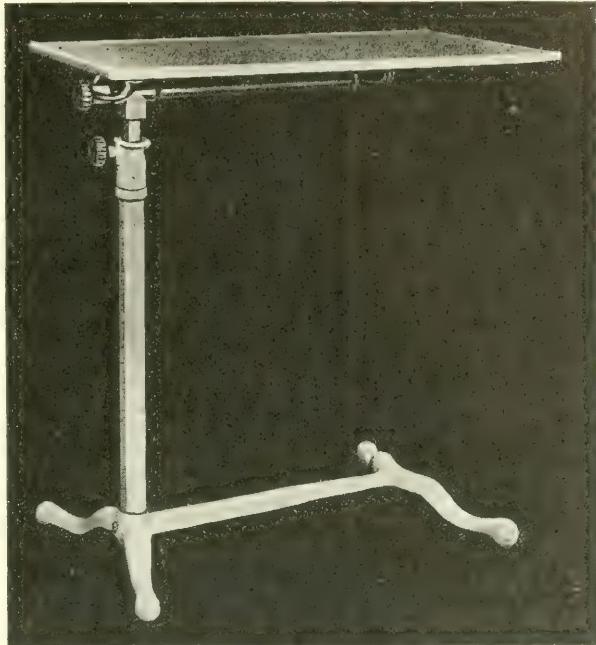
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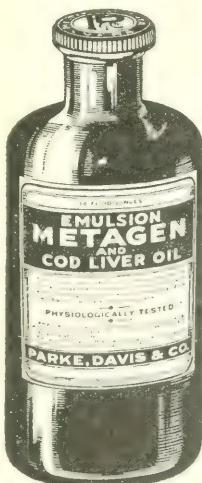
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The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire.

Vol. XXIII

TORONTO, MARCH, 1923

No. 3

Editorial

The Winnipeg Meeting of the Manitoba and Western Canada Hospital Associations

The Manitoba Hospital Association and the Western Canada Hospital Association held a joint convention in Winnipeg on Nov. 13th, 14th and 15th, just before the meeting of the Manitoba Medical Association. The meetings were attended also by members of the Western Canada Catholic Hospital Association which was holding a convention in St. Boniface at the same time. Among the visitors from a distance were Dr. Richard Olin Beard of the University of Minnesota and Dr. M. T. McEachern who, to use the stock phrase of all chairmen, "needs no introduction to this audience." Dr. McEachern reported formally on hospital conditions throughout Canada and discussed hospital organization, which was referred to more formally in discussions and in questions and answers throughout every session.

The address of welcome was given by the Hon. F. M. Black, Provincial Treasurer and acting Premier, who discussed the assistance already given by the provincial government to hospitals in Manitoba and laid stress on the need of economy.

The sessions were occupied largely by round table discussions on such topics as "Standardized Equipment," "Standardization of Surgical Dressings," "Reclamation of Gauze," "Hospital Publicity," "Publicity through the Annual Report," and "The Relation of the Hospital to the Press," "Hospital Costs," "Affiliation of Nursing Schools," "Training School Records" and "Class Room Equipment."

Among the more formal papers was a full and interesting report on the hospital situation in Saskatchewan by Dr. F. C. Middleton of Regina, Provincial Medical Inspector, Department of Public Health, Saskatchewan. This dealt with some of the problems of hospital care in sparsely settled communities and led to a discussion especially of the type of municipal hospital organized by a group of municipalities.

A paper by Miss Cotter of Dauphin on Social Service in small hospitals brought forward the needs of social work in small communities both in and out of the hospitals. In the discussion it was suggested that a solution might be found in public health nurses having smaller districts to cover, thereby being able to work more intensively than they can now.

A committee appointed in 1921 with Mr. H. G. Marton of Winnipeg as convenor, reported fully on Methods of Hospital Accounting, the findings being favorably criticised by Mr. J. D. Reid, C.A.

Laundry principles and practise was the subject of a particularly interesting address by Mr. P. H. Hammond, Manager of one of the large Winnipeg laundries. Miss Jessie Purvis of Portage la Prairie, discussed very fully laundry equipment and supplies as applied to a small hospital. Food service was discussed by Miss Gretta Lyons of the Municipal Hospitals, Winnipeg, and Miss Margaret Speechley.

The equipment necessary for laboratory work even in the smallest of hospitals was demonstrated and discussed by Dr. Nicholson of the General Hospital, Winnipeg who, in fifteen minutes, with the minimum of apparatus, actually carried out most of the essential tests.

At a public meeting, Dr. Beard of Minneapolis discussed exhaustively the report of the Rockefeller Foundation on Nursing Education. With this report in the main he agreed, but argued that the shortage of nurses to be remedied by the measures proposed by the Foundation did not actually exist. He considered the report, however, as one of the biggest events since the Rockefeller report upon Medical Schools, and likely to have an influence upon nursing education corresponding to that of the former report on medical education.

Dr. Stewart, president of the Manitoba Hospital Association, in an opening address, said the care of the sick, which had been at first a charity, was now becoming more and more a community function. It should never become entirely a community function as sickness or health were, in part at least, the results of personal care or lack of care. The small and large hospitals differed in the scope of work that might be undertaken, but in the work each set itself to do there should be one quality only, the best. That did not mean over-elaborateness in equipment. Non-essentials and unnecessary expenditures were especially out of place at the present time. All hospitals should teach, not medical students and nurses only but, perhaps chiefly, the general public. The hospital should be a centre for the health instruction of the community.

Among the resolutions passed were the following:

That the Manitoba Hospital Association endorse the principle of the supervision by the University, of standards for the teaching and training of nurses in the Province of Manitoba.

That this Hospital Association recommends for the consideration of the next executive the principle of having a central Advisory Board and Intelligence Bureau for hospitals within the Province.

WHEREAS: The American Hospital Association is international in scope—comprising Canada, the United States and all America.

AND WHEREAS: Provision has recently been made for affiliation of geographical sections, whether provincial, state or district in nature—

AND WHEREAS: Such affiliation would have many advantages to our hospital people in being part of, and closely in touch with this, the largest hospital association in the world—

BE IT RESOLVED: That a committee be appointed to bring in a report on the advisability of such affiliation and that this committee report at the next annual Conference.

Another resolution fully endorsed the movement for hospital standardization.

On the social side of the convention, the big event was a reception at Government House by the Lieutenant-Governor and Lady Aikins. Sir James Aikins was, during the past year, the honorary president of the Association and since its inception has taken a keen interest in its welfare. On the first full day of the convention, lunch was served to the delegates at the General Hospital and on the second day, at the Municipal Hospitals.

A very good exhibit of hospital equipment was in place which was much appreciated by the delegates.

Dr. C. A. Baragar, superintendent of the Hospital for Mental Diseases, Brandon, was elected president of the Manitoba Hospital Association for the coming year and Miss S. G. Johnson, superintendent of the Brandon General Hospital, secretary. It

is likely that the 1923 meeting will be held in Brandon. The future of the Western Canada Hospital Association was discussed. Some thought it had done all that was necessary when it had brought into being western provincial organizations and that it might now be dropped. Others considered it should be continued. The old executive was continued with instruction to gather opinions and make the decision.

Operating in Homes

Nurses may be called upon at times to prepare for operations in private homes. An occasional doctor does most of his operative work in the home. Some wealthy folk, in deference to their sick one's whim, arrange to have a room especially fitted for the operation. In remote country districts and in villages and towns where there are no hospitals, the doctor is often compelled to operate in the house. The nurses in the Royal Victoria Hospital, Montreal, are given special lessons on operating technique as adapted to private homes. We hope the custom is general in training schools.

Grace Rankin relates, in a contemporary, the experiences of a nurse friend who was spending a vacation on a Colorado ranch. The local doctor requested her to help him in a curettage. The cabin contained but two rooms. There were only two clean towels and two clean sheets. A number of cotton flour sacks were found. The dish pan

was well scrubbed and scalded, filled with boiling water, covered with one of the scalded flour sacks, and put out to cool. A tea kettle full of water was boiled and kept hot. This made the supply of sterile water. A bread mixing pan with a flour sack in the bottom served for the sterilization of the larger instruments by boiling in water, the instruments being lifted out by means of the sack. A thoroughly cleaned milk can covered them while boiling. A second milk can was used in which to boil the surgeon's gloves, a fountain syringe and some pledges of cotton, these being covered by another pan. Baking and cooking dishes were not used. After the boiling, four sterile containers were ready for use—the pans and the covers. The instruments on their sack were placed on an up-ended box which had been covered by a flour sack over which a very hot iron had been passed. Flour sacks, scalded and pressed with a very hot iron, followed by careful wrapping, were used to bind the patient's legs. Layers of newspapers covered with similarly prepared sacks were improvised so as to be used as a Kelly pad is. (The doctor, however, had a Kelly pad with him.)

The kitchen table was used for the operation. A rolled sheet, passing behind the patient's neck with ends tied to the legs, did duty as a leg-holder. The doctor used a kitchen chair as his stool. The "calf bucket" caught the waste. Kitchen chairs and a

box held the scrubbing up and solution basins. The doctor brought his hand brushes, which were boiled in an enamel basin.

Miss Rankin adds that a steam-sterilizer can be improvised from a common wash boiler with a tightly-fitting cover. A brick or two are placed on the bottom of the boiler at each end. A few strips of narrow board are placed upon the brick reaching from one end of the boiler to the other. Articles to be sterilized are *loosely wrapped* in gauze or pieces of linen cloth and placed on the slats. The boiler is filled one-fourth full of water. When boiling begins, move the boiler to the back of the stove or lower the fire, so that the steam continues to form, but vigorous boiling is avoided. One hour is allowed for such steaming. Dry the articles in a hot oven, but do not scorch the linen.

Miss Rankin once used a dining table for an operation. Drawing the table out to the fullest, two extension boards were placed lengthwise across the opening. On such a table a cotton quilt or clean blanket can be used as a table pad. The table end at the surgeon's right will hold the instruments; the opposite end will answer for the anesthetist's stand. For rectal or vaginal operations the table, of course, should be shorter.

Glass fruit jars will do for cold sterile water, being covered with pieces of cotton cloth tied over the tops. They are placed in a milk pan, partly filled with water, boiled for an hour and then set aside to cool. Normal salt solution may be similarly prepared.

A folding ironing board may be used, when needed, as an instrument table.

A meat platter can be sterilized and used to hold scalpels and small instruments.

Federal Hospital Bureau

Hospital Workers—trustees, superintendents, principals of training schools, and members of the medical staffs of Canadian hospitals, would do well to consider the statement of Dr. Bow, Superintendent of the Regina hospital, made at the last meeting of the Western Canada Hospital Association in Winnipeg, when he advised that there should be some federal department, whose business it would be to co-ordinate the work of institutions and hospitals in Canada. He said he appreciated the work done by the American College of Surgeons in the work of standardization, which had reflected only good on the hospitals concerned. But there was a demand for some central Canadian organization to function as a control bureau on hospital matters.

The HOSPITAL WORLD quite agrees with Dr. Bow and would suggest that this central federal hospital bureau be placed under the Department of Health, Ottawa. We would also advise the resuscitation of the Canadian Hospital Association which should meet yearly, in Ottawa (say), at which meeting representatives of all the provincial associations should be represented for the co-ordination of hospital activities in Canada.

An Ontario provincial hospital association should be formed at once to deal with all subjects in which hospital folk in Ontario are interested. We should like to see the Department of Hospitals of the Ontario Government take the initiative in this matter. Dozens of volunteer workers all over the province would hold up Dr. McKay's hands, if he but called a meeting to initiate the movement.

Each provincial association might nominate one member to a federal board. These might meet at Ottawa, as above suggested, once yearly, under the chairmanship of the Deputy Minister of Health and thrash out all national hospital problems.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

The official organ of The Canadian Hospital Association, The Alberta Hospital Association and The British Columbia Hospital Association.

Editors:

ALEXANDER MacKAY, M.D., Inspector of Hospitals, Province of Ontario.

JOHN N. E. BROWN, M.B., (Tor.), Ex-Sec'y American and Canadian Hospital Associations, Former Supt. Toronto General and Detroit General Hospitals.

M. T. MacEACHERN, M.D., Director-General, Victorian Order of Nurses, Ottawa.
W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont., Consultant, Toronto Hospital for Incurables.

MAUDE A. PERRY, B.S., Supervising Dietitian, Montreal General Hospital

Associate Editors:

Ontario

C. J. C. O. HASTINGS, M.D., Medical Health Officer, City of Toronto.

N. A. POWELL, M.D., C.M., late Senior Assistant Surgeon-in-charge, Shields Emer-
gency Hospital, Toronto.

P. H. BRYCE, M.D., late Medical Officer, Federal Dept. of Immigration, Ottawa.

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C. K. CLARKE, M.D., LL.D., Medical Director of the Canadian National Committee for Mental Hygiene, Toronto.

HELEN MacMURCHY, B.A., M.D., Late Asst. Inspector of Hospitals of Ontario, Toronto.

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A. K. HAYWOOD, M.D., Superintendent, Montreal General Hospital, Montreal.

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W. H. HATTIE, Provincial Health Officer, Department of Public Health, Nova Scotia, Halifax.

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DAVID A. STEWART, M.D., Medical Superintendent, Manitoba Sanatorium for Con-
sumptives, Ninette.

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monton.

A. FISHER, M.D., Superintendent, Calgary General Hospital, Calgary.

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M. R. BOW, M.D., Superintendent, Regina General Hospital, Regina.

J. W. S. McCULLOUGH, M.D., Chief Officer of Health for the Province of Ontario, Toronto.

J. H. ELLIOTT, M.D., Asst. Medicine and Clinical Medicine, University of Toronto.

H. A. BOYCE, M.D., Kingston, Ex-Secretary Canadian Hospital Association.

GEORGE D. PORTER, M.D., Toronto, Ex-Secretary Canadian Association for the Prevention of Tuberculosis.

G. MURRAY FLO'K, M.B., Physician-in-charge, Essex County Sanatorium, Union-on-the-Lake, Kingsville.

C. M. HINCKS, B.A., M.B., Assistant Medical Director of the Canadian National Committee for Mental Hygiene, Toronto.

British Columbia

ARTHUR G. PRICE, M.D., Medical Health Officer, City of Victoria, Victoria.

M. T. MacEACHERN, M.D., Superintendent, Vancouver General Hospital, Van-
couver.

H. C. WRINCH, M.D., Superintendent Hazelton Hospital, Hazelton.

Great Britain

CONRAD THIES, Esq., late Secretary, Royal Free Hospital, London, England.

DONALD J. MACKINTOSH, M.D., M.V.O., Medical Superintendent, Western Infirmary, Glasgow, Scotland.

United States

CHRISTIAN R. HOLMES, M.D., Cincinnati, Ohio.

MISS MARGARET CONROY, Boston, Mass.

DR. FRANK CLARE ENGLISH, General Secretary, Protestant Hospital Association, St. Luke's Hospital, Cleveland, Ohio.

THOMAS BEATH, M.D. (late Superintendent, Victoria Hospital, Winnipeg), Raleigh, N.C.

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Original Contribution

THE PHYSICIAN, THE NURSE AND THE HOSPITAL*

DR. STANLEY.

Mr. Chairman, Ladies and Gentlemen: -

Each one of the speakers before have cut out of their address many illustrious thoughts and I shall do likewise.

The question left to me is a live one, and I have promised myself fifteen minutes to give it to you in. I want to deal with the three great agencies of scientific medicine, the physician, the nurse and the hospital. Dr. Archer has given to you what we expect of a physician to-day and his position, and what he has done, and I do not think it necessary for me to repeat it, except to say that to-day you expect a physician to be a trained man, trained in the knowledge of his science, but a man with such preliminary education as will make him a student that will continue to train himself in his profession. That is what you expect of a physician, and that is what you have in a large measure in the medical practitioner in the Province. Let me say this: Professor McPhedran, one of the outstanding men, visited our Province a couple of months ago and in writing back to the president of the Medical Society he said "I have visited many associations of medical men in various countries, and I want to say this, that the medical men of the Province of Alberta are more interested, seem more up-to-date and are more actively looking for knowledge than any other group of medical men in all my experience." I can say that because I believe he meant it. It is to be expected of him that he will be a trained man. He will be able to use his own senses and this is emphasized by many of our leading men, but also he will be able to use all the facilities which scientific medicine provides to him to-day. Now probably you don't expect a general practitioner to be a specialist in all diseases, but you certainly do expect him to

*Read at the Convention, Alberta Hospital Association.

have a general scientific knowledge of scientific medicine, and the best specialist to-day in any line is the man who has a general training and a general scientific knowledge that will enable him better to practise the specialty which he chooses. I might take considerable time in going into the knowledge required by a medical practitioner to be a technician; the use of the X-ray; the use of the various laboratory facilities for examination and diagnosis of such troubles as syphilis, and the diagnosis of tuberculosis, but that would take up a lot of time, so let me go on further to repeat what Dr. Archer said in regard to surgery and the advance that has been made, and what is expected to-day of a surgeon and of a physician. He is not any more simply a dispenser of medicine, but a man who uses all means to cure the disease. Medicines have their place and in the last generation there have been many therapeutic advances in the use of medicine which we would do well to remember. But this making use of drugs scientifically is now not the only necessity, there must be absolute knowledge on the part of the physician as to what each will do. He will also use every other method. Take diet for instance. You hear of men using this particular fact of scientific medicine and stretching it to unreasonable limits in order to draw big fees from the public. The physician to-day is an expert in diet for various individual cases; he is an expert in the use of massage, of electricity and of all other various systems and means which are being used regularly as well as irregularly. But let me go on from that and repeat what Dr. Archer said in regard to preventative measures. Smallpox, yellow fever, diphtheria and various other epidemics of that kind have practically been conquered.

Now let me pass on from the position the physician holds to the position which the nurse holds. The nurse is one of the good partners in scientific medicine. Let us get that into our minds right now, she is no longer simply a nurse helping in the home. The nurse is demanded by the public and belongs to the trio which forms scientific medicine to-day; one thoroughly and scientifically trained to be of assistance to the physician. She is trained in the use of drugs, not that she

prescribes, but she knows the drugs that are being administered. She is trained in surgery; she knows the principles of surgery, so that in the operating room in the various dressings and in many other ways she is thoroughly and scientifically trained, so she is indispensable in surgery and scientific medicine, and she is trained in the use of various other means such as massage and electricity. Then I might call attention to this fact on the part of the nurse and the part of the physician: that there is being given a great deal more attention to-day to the fact of the mental condition; so to-day the physician is trained to analyse the mind, and so the nurse is trained to apply the remedy as prescribed by the physician along this line. We demand of our nurses that they have preliminary education so that they will be able to continue to study, to be able to inform their minds and to keep up with the advances in scientific medicine; for the nurse who is no longer a student is as dangerous as a physician who is no longer a student. Let me say this in regard to the nurse. She is a teacher. We are training our nurses to-day in order that they may take their part in the training school in the hospital or that they may help in the endeavor to carry on the Public Health Department, municipal and provincial; and the nurse is one of the most important factors in the health endeavor being carried on in the municipalities and throughout the Province; so, as part of a scientific medicine, she is indispensable.

The third factor is the hospital. I would like to impress this very strongly if I have the time. These hospitals are an absolute necessity for scientific treatment of the sick. It is impossible for the physician to act without the nurse, or without the hospital. I do not mean to say that every sick person should go to the hospital, but I do say this, the physician must have at his disposal all hospital attendance and all facilities in order that he may be provided with curative means and have at his disposal diagnostic facilities contained in these hospitals; so if I give you no other thought I would like this impressed as part of the scientific measure and as an early necessity for progress along health lines—the hospitals must extend. Hospitals are the centre of our health endeavors. They should be in every community; that is in every

district so that from the hospital will radiate a knowledge of health, a publicity centre if you want to use the term; an important health centre of the community. For diagnosis a properly equipped hospital must be at the disposal of the physician, in order that he may make a proper diagnosis, which must be made before a disease can be treated properly. The research work which has been going on in this generation and the generation preceding has been carried on in the hospital and, because of the research work scientific medicine had advanced to where it is to-day, and that has only been because of the facilities the hospital offered to the medical man to make these research studies, that they have been able to advance medicine to the point where we find it to-day.

Now then we have these three factors, these three great agencies forming scientific medicine. There must be full and complete understanding and co-operation between the three; the physician, the nurse and the hospital. One cannot do without the other. I had the privilege of addressing the graduating class of the Holy Cross Hospital, and in part I brought out that part in these words, using a parody upon the Bible: "The hospital, the nurse and the physician are co-partners in the science of medicine and from their nature, and necessary nature, are still separate members of this one body. For the body is not one member but several members and the nurse cannot say: because I am not of the physician I have no need of thee; nor can the physician say: because I am not of the hospital I have no need of thee, and because I am not of the hospital I am not of the body; the physician cannot say of the nurse: I have no need of thee. Nay, much more, those members of the body which seem to be more feeble are necessary. That there should be no schism in the body; but that the members should have the same care one for another. And whether one member suffer all the members suffer with it or one member be honored, all the members rejoice with it. No, these three must not be separate; the physician, the nurse and the hospital must work in complete co-operation."

Now as President of the Hospital Association I would like to deal with a position we find ourselves placed in in regard to the hospital. Let me say this before I commence dealing

with that, that we have advanced in this Province probably more rapidly in the matter of hospitals than in any other Province in the Dominion of Canada proportionately speaking, and let me offer words of praise in connection with the administration of the hospital department in this Province, and the endeavors being made by the Honorable Mr. Reid in conducting the Department of Health and particularly conducting the Hospital Department, the rural hospital as organized, having done magnificent work. The rural hospitals in this Province are doing a magnificent work and filling a great need. I say this because when I follow up with the remarks I am going to make in a moment, I do not want you to understand I am offering any criticism but simply offering suggestions of what can be done for the future, setting out some future endeavors and ideals to which we may reach out and which we can hope to attain within a few years, and perhaps not so far off as some might imagine. The point is this, that if the physician, the nurse and the hospital are unquestionably factors in scientific medicine, then in all fairness the hospital should be available to all citizens on fair and equitable terms. I think that is reasonable. Something that perhaps cannot be attained this year or next year, but it can be attained within the life of most of us sitting here to-night.

What is the position in this Province to-day? The citizens of this Province cannot obtain hospital facilities on fair and equitable terms, and they will never attain them until we have a Provincial system which shall place at the disposal of every citizen the hospitals of the Province. What is the position to-day? We have our hospitals, the larger hospitals in a few of the larger hospital cities, Edmonton and Calgary, Medicine Hat and Lethbridge. We have another number of hospitals, I cannot say how many, privately owned by various organizations and conducted by them upon philanthropic and charitable contributions. Then we have the municipal hospital which is carried and financed by the fees that are paid in and by taxation which is imposed. Now here is the point: supposing a person lives just outside the municipality or just outside of a rural municipal hospital district. Then he is charged a prohibitive rate in order to obtain hospital facilities.

For an outside patient wishing to come into the general hospital he finds a charge of \$4 a day for the public ward, and he finds there a double rate for the use of the laboratory, the use of the X-ray and the rest of the diagnosing facilities. He finds a large fee for the use of the operating room and so on. Then you take in regard to the rural hospital. If a person is fortunate enough to be within the confines of the rural hospital, then he receives the facilities at \$1 a day, and if across the road then he has to pay, I think it is, \$5 a day. \$5 is prohibitive almost to the ordinary settler. Here is the way I see it. I am not offering criticism, but I am pointing out the position in which many citizens find themselves to-day. What is the remedy? Before I take that let me point out another fact in regard to the pioneer people and those living in foreign districts. We hear cries for medical service and there is no question, it has got to go back to what I have already told you and you will see the almost entire futility of sending a medical man away into the pioneer districts, absolutely shut away from the use of the hospital and the nurse, to go out and try to carry on his profession and assist these people. He could probably give some assistance in some cases, but generally speaking, his efforts are wasted, so that as a matter of fact the medical practitioner who goes away out to the outlying district, goes in a missionary spirit and very often is wasting his time. He might do far better work at some other point. I am not trying to discourage the medical man, but I do want to emphasize this: that it is in these pioneer districts that the hospitals need to be provided so these districts may have the use of the hospital, in a small way no doubt on the start, but will enlarge as time goes on. Now what is the system? I would say a Provincial system. I am not advocating, and I am not going to say anything to-night about the free hospital; we hear so much about free this and free that, but some person has to pay the bill; that is another question—when I speak of the Provincial system I do not necessarily mean all must be municipal hospitals, but I do mean this, that the Provincial Department of Health should take such control over the administration of the hospitals of the Province so that they would be able to administer and classify to some extent these hospitals, so as to

provide for any one particular local district and for the Province as a whole. Take the rural districts, the hospital districts under the Municipal Hospitals Act. They throw a boundary around themselves and no person is allowed—they are allowed but not invited to come in—that is for the rate-payers within that municipality. The point I am getting at is this: the Department of Health should have sufficient administrative authority to be able to locate the hospitals throughout the length and breadth of the Province and should be able to classify these and define the work they will do. That is a large question; suffice it to say this—when it comes to a matter of dealing with contagious disease, when they come to dealing with tuberculosis, that brings you to the point where you have got to have certain expenditures, certain facilities, that cost a great deal of money. It is not necessary for each district to provide for all of this, but with one system of distribution by the Department of Health these could be provided so that the whole Province be provided for in a fair way. That does not obtain at the present time. If this district wishes to have diagnostic facilities going to cost a great deal of money, they must buy them and put them in there; the same thing with the next one and maybe you are duplicating. You will be duplicating time and again this expensive work. Now you say that costs money. Yes it will. Would it not be better to centralize entirely in Edmonton or the larger cities because the municipalities object to the Federal or the Provincial Government taking any of their power from the municipal authorities? We realize that, but the central department of health certainly should have central administrative authority in order that they will be able to make our system so that every person in the Province will be able to receive hospital facilities on fair and equitable terms. If the central department of health takes authority they will certainly have to give the municipal authorities some financial reimbursement by making good the authority taken from them. We have done it in regard to the schools. Schools have local administration with certain restrictions which are retained by the Department of Education. The hospital will have local autonomy under certain restrictions which will make that a complete Provincial system

harnessing the work into a system which will be set down for the care and accommodation of the sick. How can that be done? It will be done by a system of grants. Let the hospital which renders certain facilities receive a grant for it. Then what? It will mean that it will be a tax. The Provincial Government cannot get money out of the ground; it comes from your pocket and mine, and it will have to be raised from the taxpayers of the Province. That will mean a health tax, but I do say this, people in this Province will be quite prepared to pay their share, and it will be necessary to give hospital accommodation to the people of the Province so that every person will receive hospital accommodation on fair and equitable terms.

HOSPITAL RECORDS*

ROY KINGSWOOD, M.D., CHIEF RESIDENT SURGEON, AND
GEORGE A. RAMSAY, M.D., REGISTRAR, VICTORIA HOSPITAL,
LONDON.

A hospital may be described as a public utility filling a position of need. As such, its function is to give efficient service. In that service how do records function?

The patient has the priority of claim and has the right to expect such thoroughness as is included in an effective record.

The physician fulfils a duty to himself in giving to the patient such study of the diseased condition as is outlined in a record.

The public, whose institution the hospital is, has a right to feel secure that the procedure therein is thorough, painstaking, logical, in order that conservation of life may add to community assets.

The institution needs to know that it is discharging its full duty to the community through its staff and officers, to the end that efficient service may become its tradition in perpetuity.

* Read at the Clinical Congress of American College of Surgeons, Boston, Mass., October 16th, 1922.

These are axioms, and, it is with their application that we are concerned.

Records are financial, social and medical. With these last, I propose to deal. While mindful always of the requirements of the standards set by the American College of Surgeons, I want to warn against records kept merely as so much manuscript, with no attempt at application. Likewise would I add my protest at any attempt to make the hospital fit the record, and not the record to blend with the character of the hospital.

In arriving at what might serve Victoria Hospital, London, we made an analytical examination of at least thirty sets of hospital forms and chose what seemed most applicable to a municipal hospital of 400 beds for public and private patients, comprising the whole series of types of service, selecting what seemed to be our particular needs, discarding much and here and there contributing some little thing that appeared to warrant a trial. There was an effort made to link in harmonious union with hospital records those documents required in dispensary and follow-up social service. We had the satisfaction afterwards of seeing almost an identical system described for a hospital that compared with ours in size and service.

The requirement which guided the adoption of any form was that it should be simple in legend and complete in the outline which should guide the investigator, leaving always scope for individuality. I protest against such efforts toward standardization as would stamp out individuality. Again, in the interests of economy, of time and money, we endeavored to secure such procedure as would make every single effort at record, from admittance slip to discharge certificate, a constant working tool, and a permanent document. It is easy to carry system to such a degree that it enslaves. Re-duplication may weary and discourage even the most energetic.

The end purpose of a record is a diagnosis demanding complete, prolonged, and detailed study of the patient from physical, mental and psychological view-points. In this evolution of analysis the record should always be a guide to investigation, an adding machine of daily and hourly obser-

vations to the ultimate totalization of a diagnosis of the patient, not alone of his disease. Nor does it stop there. Treatment follows on the conception of the cause, course, and expected outcome of the condition and is varied to meet its changing phases. If then, it gives proof of intelligent endeavor, it requires a record, and if it fails, simple honesty likewise requires a record of what has been tried and found wanting.

I wish to quote Dr. Emerson's definition of a record. "It is not our imagination or our memory of past events, but a painstaking entry on imperishable human documents of what is at the same time the glory and the humility of medicine, the truth as we see it, when we see it, the facts as our faltering and unskilled senses take note of it, whether in the immediate presence of suffering humanity, or at the operating or autopsy table, while still the echo of the laboratory test is knocking at our conscience. The present is ours to record. To-morrow belongs to the past." The terse definition by Father Moulinier is that a record is a collection of facts that you find, filter, focus, and then face fearlessly.

I wish to acknowledge the pioneer work of the late Dr. J. L. Stapleton in laying the foundations of our record system in Victoria Hospital, London. This was carried on by Dr. J. R. N. Childs and I acknowledge gratefully also the sympathetic support of trustees, staff, internes, and record clerks in making the effort possible.

Our method of procedure at Victoria Hospital may be best explained if we take an actual case and follow it through the hospital from the time of admission until discharge from the hospital.

History. Mr John Doe enters the hospital on July 3rd, 1922. The necessary notification to the attending physician, interne, etc., has been given. The interne visits the patient—shortly after admission, not with a huge pad of record papers in one hand and a fountain pen in the other, but purely to meet the patient, become acquainted with him, and to make sure that his wants are being supplied. This gives the interne his approach to the patient. Then sometime, within a few hours, he is able to obtain a history which is a real record of the patient's condition.

The history embodies his (1) chief complaint; (2) mode of onset of disease, which is really the explanation of his chief complaint; (3) short past and family history. We ask that these statements be concise and bear directly on the case.

Physical Examination. The interne then proceeds to his physical examination of the patient. We require this to be complete and if there are any findings in his examination which are indefinite we ask that he call in one of the senior men to assist him. We suggest that the interne start his examination at the head and proceed downward to the feet, taking the various systems in order. Probably the two most important items upon this form are (1) Working or provisional diagnosis. This is the interne's honest, working diagnosis of the case after he has completed history and physical examination. We ask that he hold to his opinion until someone with more experience proves that he is wrong. We do not have to have this diagnosis absolutely correspond with our final diagnosis, but in his discussion of the case he obtains his training and the patient may benefit by more careful investigation. (2) Read by Dr. This is written on the bottom of the chart after the visiting doctor has read the history and physical examination. This shows the interne that the doctor has been sufficiently interested in his findings to at least have read what he had written.

Progress Notes. This is a record of the patient's general and post-operative condition, and explains the healing of the wound, etc. It also gives the opinion of any doctor who may have been called in consultation on the case. These progress notes are to be written at least every three days, and more often in serious cases.

Operative Record. This is a detailed record of the procedure, technique, pathological findings, etc., at the time of operation. Dictation is carefully given by the surgeon or senior assisting interne immediately following the operation. On a busy morning the stenographer takes the dictation in the operating room.

X-ray Report. A report from the department of roentenology would be found on case of renal calculus—a miniature reprint of the plate is shown in the upper half of the X-ray form, with the dictation below.

Laboratory Finding. The laboratory findings are recorded on the usual printed form and include, urinalysis, blood and serological report. The work of the laboratory technician is supervised by the interne on service. The Institute of Public Health and the Western University Medical School laboratories co-operate with us in the more difficult laboratory findings.

Nurses' Record. A record written by the hall nurse of the patient's general condition, medication, treatment, doctor's visits, etc., is carefully kept. Too much cannot be said for the nurse who carefully observes the patient and then records her observation. She has a greater opportunity than either the visiting physician or interne.

Dental Record. To make our record complete we have a record of dental examination, extractions, prophylaxis, etc., as advertised at our Wednesday morning clinic.

Chart Foldery. These are in two colors—yellow for female patients and white for male.

On the discharge of the patient from the hospital the interne is responsible for checking the chart to make sure that all records are complete. It is then placed in the chart folder, properly filled in, the discharge diagnosis completed and presented at the record office for the approval and signature of the Director of Records. The charts are then filed by the record clerk, according to our number and cross index, according to disease.

Our record of histories secured for the months of September and October was 100 per cent. on each of staff wards, semi-private wards, private wards.

Just a word as to how we obtain our records. The interne on the ward is responsible for the history and physical examination. By his gentlemanly and professional approach and by making sure that the patient has become partly acclimatized to the hospital he wins the confidence of the patient. We require that a nurse be present at the examination of all female patients and that the patient be draped in such a manner as to insure thorough examination and yet not offend the delicacy of the patient. In this way our private patient

co-operates with us. We also have convenient places, such as sun-parlors, etc., where internes may write their records without being disturbed. Many discussions take place here which prove beneficial to internes, and we trust, to the patient.

Our record office is not a spacious or palatial room. It is small and compact, but often a busy place. Here, the operating and other important dictation is given to a stenographer. Here, also, are the completed charts numbered and filed in cabinets for future use.

We consider our internes as one of the spokes in the wheel which turns our machinery. But, perhaps, your hospital has not the facilities for obtaining internes to carry out record system. Perhaps the doctors, themselves, do not think a record system necessary in your hospital of fifty, seventy-five, or one hundred beds. Perhaps they are busy men and have not the time nor inclination to record their diagnoses, observations, and treatments. We realize that many of the smaller hospitals, not as favorably situated as Victoria Hospital, have at present difficulties which we have not encountered. Nevertheless, every hospital no matter what bed capacity, in fairness to the patient, doctor, medical profession, and the community at large, should at least make an honest attempt to meet the requirement of the minimum standard of the American College of Surgeons.

We make the suggestion that hospitals of fifty beds or more could unite their visiting doctors in the form of a hospital staff under the direction of a chief of staff. The details of the minimum standard could then be placed under their jurisdiction. A stenographer could be retained who would have charge of the record room, taking dictation, filing charts, etc. A graduate nurse could also be obtained if it was thought advisable to procure a graduate doctor as interne at first, who could, under direction of the physician, obtain the history, write progress notes, etc., and even perform certain laboratory technique. Doctors will find the Public Health Institutes of the Province eager to assist them in any laboratory investigation and graduate nurses from the Department of Public Health prove valuable hospital executives. The physical findings could be given to the nurse or stenographer by the visiting doctor. This would at least be a step in the right

direction and the expense would be very little, in consideration of the advantages to both patient and doctor.

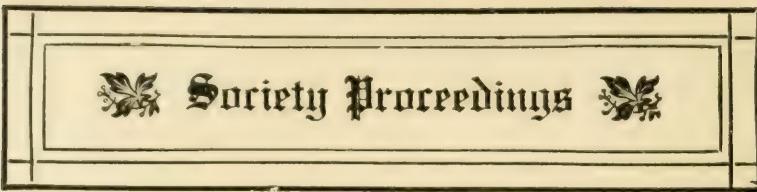
The advantages of a record system might be briefly mentioned. The staff can meet at stated intervals to discuss cases, either discharged or at present in the hospital. This leads to staff-conference analyses and the promotion of scientific research.

On the re-admission of a patient who has had a previous operation it is of decided advantage for the doctor to be able to refer to the previous operating-room report for concise details.

A patient who has been treated in a hospital in another city moves to your location. You are called to see the patient who explains that she has been under treatment at such a hospital. How satisfactory to you to be able to obtain her diagnosis, treatment, etc., from that institution. How much valuable time is lost to the patient and to you if such a record has not been kept carefully. The advantages of a record from medico-legal aspect must not be forgotten, also.

But someone has said our record system must cost considerable money. We have worked out our per capita record cost and find that it averages fifty-one cents per patient.

We, therefore, put the question before you: Is it worth while? Does it pay?



Society Proceedings

HOSPITAL JOINT CONVENTION

This meeting was held in Winnipeg in November last, under the presidency of Dr. George F. Stephens of the General Hospital in that city. Hon. F. M. Black welcomed the delegates. "When we measure the progress of our own nation," he said, "and the so-called Christian nations against those who have not that Christian faith, we then see at once what a real progress has been made . . . We are justified in considering your profession the second greatest, allowing those who attend to the spiritual interests of mankind as the highest."

"In four years past the Province of Manitoba has paid out in grants to hospitals \$528,000, and in building subsidies, \$177,200, of which the Winnipeg General Hospital has received \$80,000. The Province allows about ten per cent. to the cost of every new building erected.

"How long are we administrators of public funds likely to continue to make such grants, in view of the avowed intention of the public not to pay any more taxes?"

Dr. M. T. MacEachern gave a lantern talk illustrating various phases of hospital, health and welfare work. He also gave an address on Annual Reports. These reports, he said, should give an account to the public of what hospitals are doing, particularly of the good done by the money spent. The statistical portion of reports—the value of which some people questioned—he was not sure should be included. Social Welfare work and Ladies' Auxiliary doings should be recorded.

Dr. Barrager, Superintendent of the Manitoba Hospital for Mental Diseases, Brandon, said: "Our reports practically never reach the public—they are not of sufficient volume to send about."

Dr. Barnes, Superintendent of the Manitoba Hospital for Mental Diseases, Selkirk, thought that the ignorance of the general public in regard to mental hospitals was the most lamentable thing in Canada. "Our hospitals are forty per cent. overcrowded. The public should be made to realize this, in order that conditions might be ameliorated."

Mr. Hartism, a trustee of a small hospital, said in his hospital the report contained the financial statements, and some statistics regarding patients, but thought that pictures of the actual work carried on would be a good thing to add. "If there is any lack in the hospital the public should know of it."

Mr. Darrow, a trustee, stated that the technical information in reports was of interest merely to the medical and nursing staffs. The report should be printed and circulated throughout the hospital's constituency. It should also be published in the local newspaper, even if such had to be paid for.

Dr. Bow, Superintendent of Regina Hospital, said the attitude of the public to the hospital was one of indifference. This was due largely to the attitude of the hospitals. Too often the press was left in the dark as to what was occurring in the hospital. In addition to the annual reports, supplementary reports of Trustee Board meetings might be given the press.

Mr. MacNeill, trustee of Dauphin hospital, stated that for the first ten years of their hospital's existence reports were gotten out, but "they got it into their heads that it was costing more than it was worth." He was afraid they had made a mistake—the public should periodically have before it a picture of what the institution was doing.

Dr. Stewart said when writing his reports he kept three people in view—the man a thousand miles away engaged in the same sort of work, a member of the hospital board who needs educating, and the general public. Perhaps we should have two reports instead of one—one technical and one popular. An Eastern hospital headed its annual report "The Story of Such and Such Hospital;" a note worth striking.

The press has a right to news, but it doesn't want any dead, uninteresting stuff and it is not a free advertising agency. The press is a gentleman; the press is a lady, and if that fact is kept in mind hospital executives will get in better with the press than if they lose sight of this fact.

If there is some story that is apt to get into the press and you want to keep it out, the best thing to do is to tell it to a newspaper man and tell him all about it and the cause. The worst thing you can do is to try and kick him out of the door.

Dr. Bow recommended that hospital executives should take the press into their confidence. There were many stories of human interest that could be published in a professional way which will reflect credit on the hospital and arouse the public interest. Hospitals have only themselves to blame if the local press fails to take the proper attitude toward the institution. If a hospital has a deficit, that can be featured. The success of an institution cannot be measured by the fact that it is operated with a surplus. The public should be shown what the hospital has done for the money expended. A deficit usually represents the cost of caring for non-paying patients. The financial aspect of the hospital should be presented in a very clear-cut manner; not that it is being run for a profit, but organized and equipped to give the highest possible service; that it costs money to do this, and if it does this work the public must not expect the hospital to be a big revenue producer.

The work in the children's and maternity departments may be featured in connection with women's organizations.

Mr. Darrow thought every hospital should have some discreet person whose business it is to prepare items for the press. There were certain discreditable happenings in hospitals which should not go before an undiscerning public.

Dr. Stewart thought the giving out of news ought to be the work of the superintendent of the hospital.

The meeting then discussed some questions. Someone asked for the best method of sterilizing cutting instruments. Sister Charles of Vancouver, replied that in her hospital they soaked these instruments for ten minutes in pure carbolic acid. Two minutes in boiling water was sufficient. In reply

to a second question, should a patient suffering from tetanus be isolated? opinion was divided. Further answers to questions were: An X-ray technician if injured is personally responsible unless the hospital has neglected the requisite safety precautions, or has employed an incompetent man.

Members of the staff in Brandon Hospital are paid salaries of three or four weeks' duration. If the sickness is more protracted the official is sent home and his pay stopped. More consideration is given to employees who have been long on the staff than to those who have only been employed a short time.

Dr. Berrager said that in his hospital all employees have sick pay for a month and permanent employees up to one year.

Mr. Stoker, Secretary of the Hospital Commission, Winnipeg, said that anybody who had been with them for twelve months was entitled to twelve days sick pay in the year—unless the illness was of a contagious nature, in which case a maximum of thirty-five days was allowed.

Mr. Darrow said he thought something ought to be done to induce laymen to come into the hospital association. This could be done if the professional element would come down to earth and talk to those who do not understand professional terms in words they knew the meanings of: Instead of being only associate members of the Association, the speaker was of opinion that trustees should be eligible to active membership. These trustees were the bone and sinew of the whole hospital body. Having to do the financing, they were surely worthy of full membership.

Dr. Nicholson was asked to specify some of the principal items for the equipment of a small laboratory. He mentioned first a glass slide and illustrated the process of securing a smear. He next described the method of staining, and of using a hemoglobinometer. He said the Burroughs and Wellcome Company put up stains in a very convenient form for use. They published a small pamphlet concisely describing how the stains were to be used. A microscope was needed for making examinations of specimens. A centrifuge was not an absolute necessity. By standing, fluids would form a sediment. Material and glass tubes needed for testing for albumen and sugar were indispensable. The technique for kid-

ney-function tests was then described. Dr. Nicholson pointed out that laboratory work could be done in a small side room. A good standard blood counting apparatus should be procured.

The Chairman commended Dr. Nicholson for demonstrating to trustees present that a great deal of very useful laboratory work can be done with very simple and inexpensive equipment.

Miss Edith Moffat described the technique employed in the operating room of the General Hospital, Winnipeg. The room is thoroughly ventilated. Every ledge and article of furniture is washed with a two per cent. lysol solution. The floor is scrubbed with lots of soap and hot water. Linen and dressings are sterilized in an auto-clave, for one hour under a pressure of twenty pounds of steam. Charts show the number of inches of vacuum, time of each sterilization and number of pounds pressure used. Diack's sterilizer controls are also used, one tablet being placed in the centre of each drum sterilized. A ten-inch vacuum is insisted upon, which means 14.7 degrees under atmospheric pressure. Without a vacuum one might as well not sterilize at all (the speaker maintains) as "steam will not penetrate where air pockets exist." The water is stone filtered and sterilized by boiling. Talcum powder is sterilized in a large open tray for one hour every day, before using it for powdering gloves or filling shakers, when it is re-sterilized. Saline solution is filtered three times, then sterilized three times, twenty-four hours elapsing between each sterilization. Silk, linen and silk-worm gut sutures are sterilized for one hour and preserved in alcohol. They use Perfection catgut. It is boiled in the tubes for half an hour before being used. Instruments are boiled for seven minutes. Knives are wiped off with alcohol and boiled for one minute. Instruments which have been used in septic cases are washed under running water and boiled from fifteen to twenty minutes. Linen used in septic cases is soaked in a solution of lysol for one hour, before being sent to the laundry; and all furniture, cushions and floors, are washed off with lysol.

The operating room is not fumigated. Soap, water and sunshine aplenty will do instead.

Surgeons and nurses scrub their hands and arms for seven minutes, then wash off with alcohol. Then cap, mask, gown and gloves are put on. Gloves are washed, boiled for three minutes, dried, mended, tested, packaged and sterilized for fifteen minutes under twenty pounds steam pressure. The gauze used in the operating room is not washed and re-used there. Gauze in clean cases is saved, washed in the laundry and sent to the wards. Woollen blankets are not used on account of the fluff and lint. The temperature of the operating room is kept at seventy-six degrees.

Dr. Stephens said there was no reason why reclaimed gauze should not be used for dressing purposes. Indeed, surgeons in some places asked for washed gauze in the operating room. The reclamation process consists in sorting out the gauze, soaking it five minutes in cold water to loosen the blood clots, placed overnight in a soda bath; then it is given a rinse and boil; then put in warm soapsuds for twenty minutes; then with a light soapsuds and a bleach it is boiled; then given one lukewarm rinse and two cold rinses; thence to the gauze sterilizer; thence to the wards.

Miss Johnston said she had observed one of Diack's controls which did not fuse, when two others did. Miss Moffatt had observed this also, but when the control was put back a second time it fused.

In discussing standardized equipment, Miss Johnston thought it would be an economy to discover one type of each article of hospital equipment—the best, and use it everywhere. The Fowler bed, she found very satisfactory, as an example.

Dr. MacEachern suggested that a committee be formed to study and report on standardization of equipment.

Dr. Stewart suggested the appointment of a committee on hospital planning and construction.

Dr. Stephens queried whether it was wise to have a Western Canada Hospital Association or separate Provincial bodies. A scheme might evolve whereby representatives of the various Provincial bodies would come together yearly as at present, in association with the local meetings. While many problems were identical that of legislation was for each Pro-

vincial body to settle for itself. Also the suggestion that these Provincial bodies might be considered geographical divisions of the American Hospital Association might be considered.

"There is (I believe), a National Association in Canada which was organized some years ago, but which, if not dead, is at least hibernating somewhere in the vicinity of Montreal or Toronto."

Dr. Stephens then discussed the question: Why is hospital treatment so expensive? With the growth of medical science hospitals have been compelled to add new departments and this meant added cost; until nearly all hospitals were laboring under financial difficulties. In spite of this, criticism was often made of the type of service—were the patients receiving the benefit of those scientific aids to diagnosis and treatment they had a right to; and were nurses receiving adequate training?

In Western Canada the allowances made under present legislation made it extremely difficult to keep up standards of service.

Hospitals should keep within their income. To do this one was faced with two alternatives—either to curtail the service or increase the income (a far more desirable thing to do). And here was where publicity came in. The public should know why hospital treatment costs so much. Let the public behind the scenes. The ordinary hospital visitor gets only a superficial glimpse of the work of the hospital. He sees the patient, the nurse, the doctor, the medicine, the food tray; but not the kitchens, the food distribution, the store-rooms, the purchasing, the operating suite with its personnel and technique, the laundry, and the power plant.

The press was the broadest and farthest-reaching publicity medium and was always ready to give legitimate publicity to hospital work. Movies are an ideally educative medium and afford an easy method of reaching a large number of people in a telling manner. Hospital exhibits at local fairs are useful. Direct visitation to the hospital should be encouraged on special days and on National Hospital Day in particular.

WINNIPEG HOSPITAL CONVENTION

At the meeting of the Western Canada Hospital Workers (partly reported in our last issue) Dr. Middleton, Assistant Commissioner of Health, Saskatchewan, gave a review of the hospital situation in Saskatchewan. During 1921, forty hospitals provided accommodation for treatment, receiving financial aid from the Government. This includes the sanatorium at Fort Qu'appelle and the Pas in Manitoba, the latter receiving patients from the Cumberland House district. The hospital at Big River closed, owing to the cessation of mining activities. The Robart Hospital was closed, but re-opened with the assistance of the Red Cross. Red Cross outposts in several outlying districts are being assisted. These consist of small houses fitted with two or three beds for maternity cases. The Government hospitals furnished 2,116 beds: general 1,502, isolation 218, tuberculosis 396—one bed for every 358 of a population. The Saskatchewan hospitals admitted 29,944 patients in 1921—one in twenty-five of the population. Twelve thousand three hundred operations were performed, 2,025 being gynaecological. There were 3,662 abdominal operations. Three thousand five hundred and twenty-four maternity cases were cared for—about one birth in six taking place in hospital. One thousand and thirty-two deaths occurred in hospitals—3.5 per cent. of total admissions. There were 121 deaths from puerperal causes in the Province, forty dying in hospital. The government grant was \$255,215.50, \$8.50 for each patient. The average length of stay was 16.7 days per patient.

Only fifteen hospitals conduct training schools for nurses. Eight nursing housekeepers graduated from the smaller hospitals. There are seventeen nursing housekeepers in training. Several hospitals have introduced the eight-hour day. The result is much less time off by sickness. Some of the smaller hospitals have affiliated with larger hospitals for nurse-training. It is probable that all pupil nurses in training will receive a part of their training at a tuberculosis sanitarium. It has been urged upon the Government that hospitals receiving government aid should be required to set aside ten per cent. of their beds for tubercular patients. This would enable the sanitarium to accommodate a larger number of cases

from unhospitalized areas than at present. More sanatoria are needed. In 1921 general hospitals cared for 184 cases of pulmonary tuberculosis.

The cost per day per patient for 1921 was \$3.15. In British Columbia it was \$3.35. Costs are going down somewhat. Steps have been taken to have all hospitals adopt a uniform method of accounting. The Government suggests costs be apportioned thus:—

- (1) Operating—salaries, wages, provisions, fuel, light, power, medical supplies, sundries.
- (2) Maintenance—buildings, grounds, furniture, equipment, dry goods, sundries.
- (3) Administration costs—salaries for this work, office expenses, sundries.

Forms as supplied and monthly statements as above are sent in. Comparative statements are made and mailed to the chairman of each Union Hospital Board; this enables the different hospitals to compare various costs.

On May 12th—National Hospital Day—there were inspections of hospitals and nurses' homes; graduation exercises for nurses; baby competitions and pamphlets issued describing services rendered.

An endeavor is being made to introduce standardization. Staffs are being organized. Memberships thereon are being restricted to competent and worthy men who will not divide fees; and the holding of staff meetings—a clinical audit—insisted upon.

There are five hospitals of 100 beds and over, four of which have fulfilled the requirements of the minimum standard. There are six of between fifty and 100, four of which have standardized. In Manitoba, there are two hospitals of between fifty and 100 beds, one of which is standard; six of 100 beds; four of which are standard. In Alberta there are two hospitals of between fifty and 100 beds, one of which is standard; six of over 100 beds all of which are standard. In British Columbia there are six hospitals of fifty to 100 beds; one is standard. Six of over 100 beds and over, all are standard.

Since 1919 twenty Union Hospital Districts have been established, but in only nine has a vote been taken. Of the remaining eleven, seven will be dis-established at the request of the Hospital Board without a vote.

Two new hospitals are being built—a twenty-five-bed union hospital at Unity and a twenty-bed at Hafford. The eleven union hospitals serve thirty rural and thirteen urban municipalities.

In reply to what "union hospitals" meant, Dr. Middleton said they were eleven hospitals of from twelve to forty beds built in rural districts, operated and maintained by as small an area as two municipalities and one urban centre, which issue debentures and build the hospitals. The average actual capital cost is eighty-eight cents per quarter section. To provide hospital accommodation for those who have entered into the union hospital scheme, they pay as high as two mills on the dollar on their assessment for hospital purposes; so that the people who have entered into this scheme—husbands, wives and children—who live in that area get their complete hospital accommodation as they do their schooling. This does not include medical attendance. Patients may choose their own doctor. The plans of projected hospitals and of alterations must be approved by the Commissioner. A special set standard of equipment has not yet been demanded. This is being aimed at. The Government contributes fifty cents per day per patient. The plan is working out very well. The smaller hospitals are designed more particularly to do maternity work; it being thought wise to refer major operative work to the larger hospitals. Patients from outside the district are required to pay. If the patient is indigent, the secretary of the hospital sends the account to the municipality from which he comes. The work goes on in these union hospitals much as it does in the ordinary community voluntary hospital. In many districts there would be no hospital were it not for this scheme for union hospitals. In establishing new hospitals care is taken to see that they do not encroach on the territory of a hospital already established. These hospitals are all inspected yearly by a government representative.

Canadian Hospitals

GRADUATION OF NURSES—ROSS MEMORIAL HOSPITAL, LINDSAY, ONTARIO

The graduation exercises of the Ross Memorial Hospital, Lindsay, were held in the Academy of Music, on Thursday evening, November 3rd, 1922, when a class of seven nurses received their medals and diplomas.

The popularity of the Ross Memorial Hospital and the community interest in the training school was clearly demonstrated when the large auditorium was crowded long before the time set for the programme to commence. It was of particular interest to Lindsay to have one of its former boys back to give the graduation address on this occasion, in the person of Dr. Malcolm T. MacEachern, General Superintendent of the Vancouver General Hospital, and now Director General of the Victorian Order of Nurses for Canada, at present engaged in making a survey of Canada for that body. In addition, he had recently been made President-Elect of the American Hospital Association, one of the highest honors in the hospital world. For many years his name has been closely associated with the hospital standardization movement, and he has done much to improve our Canadian institutions of this nature.

The following nurses received their medals and diplomas:

Mabel Amy Flinn, Marion Jean Murray, Lila E. Ward, Florence L. Greaves, Amy N. Spence, Aileen Flett, Bessie P. Cresswell.

The stage arrangement was a most impressive sight. The chair was occupied by Mr. J. D. Flavelle, Chairman of the Board of Trustees. The medals were presented by Mrs. Thomas Stewart, and the diplomas by the Chairman, Mr. Flavelle.

Many interesting addresses were given by various representative speakers, including His Worship, Mayor O'Reilly, Senator McHugh, G. F. Sandy, Esq., M.P.P., the Very Rev. Dean Whibbs of St. Mary's Church, Canon Marsh of St. Paul's Church, who represented the Ministerial Association,

and Dr. Blanchard for the medical profession. All speakers referred with enthusiastic praise to the high degree of efficiency of the Ross Memorial Hospital and its training school. Many references of a eulogistic nature were made to Miss E. S. Reid, Superintendent of Nurses, a graduate of the Ross Memorial Training School and a young woman showing remarkable leadership.

The address to the graduating class by Dr. MacEachern, the speaker of the evening, was extremely interesting, and was followed with the keenest interest by every member of the vast audience. It was indeed a fitting exhortation to send them on their way.

The speaker opened his remarks with reminiscences and congratulations—the former on account of the pleasant associations with the town, where he received his fundamental education, the latter on account of the splendid Ross Memorial Hospital and Training School for Nurses, and above all, for such splendid men of service guiding its destiny, as Mr. J. D. Flavelle and Mr. R. J. McNeilly, Secretary, both outstanding men of vision, public spirit and community service.

Following this he briefly and logically traced the various steps in the history of hospitals and nursing through many difficulties and dark ages to the present day of modern development. The speaker said: "Nursing is as old as creation, but trained nursing is a development of the past century. We now find splendid training schools all over our country, filled with the flower of Canadian womanhood. Not only have you been admitted to this profession because you wanted to enter it, but the hospital has accepted you as a member of the training school after careful investigation, morally, mentally and physically, and further, after you were obliged to demonstrate your fitness for such work. Therefore, you are a select group." The speaker emphasized the importance of the nursing service in the hospital if it is to render the right kind of service in the community and thus retain the confidence thereof. He said: "As a hospital administrator for twelve years, I cannot emphasize how important I consider this nursing service rendered for the success of the institution. It

must be a service anticipating and meeting the patients' needs at all times. It must be a service which satisfies. Our hospitals stand or fall on the type of service which we render to the patients therein."

In conclusion, the speaker addressed his remarks particularly to the graduation class, as follows: "We have watched your careers during the past three years with interest and pride, and now at the end of this period your apprenticeship in the greatest profession that woman can claim solely as her own, is ended. On the threshold of your graduation I congratulate you and wish you great things indeed.

"Completion of your course and graduation marks another beginning or commencement in your lives, and from now on you will be much less guided than in the past three years when you have been under the caring eye and direction of your training-school officers and the hospital administration generally, by virtue of you being a member of this large family to which you will always belong.

"Let us reflect for a moment on the three years which have so quickly and so happily passed and what you have really gained from the vast experience that you have had during this time. You have accumulated an abundance of technical knowledge to equip you to take care of the sick in an intelligent and efficient manner so far as nursing of them is concerned. This knowledge is yours and is something which no one can ever take away from you. Your training, however, has done more than this for you. You have developed qualities of character, of disposition, and of culture not common always to other groups of women outside of your profession, and all this through your intimate relationship and experience with human life in all its phases. You, as no other group of women, have had an opportunity to study human nature at close range and by intimate contact with its impatience, its failings, its eccentricities, its peculiarities and other characteristics. You have come in contact with the experiences of life which mould and develop character-producing, outstanding qualities which make you better, bigger and nobler women in every sense of the word.

"Your experience has given you a trained mind to think clearly and to act precisely, and has taught you to be human, to be kind, sympathetic, tactful, honest and optimistic in the performance of your duties and your daily routine, and to take the bitter with the sweet, the difficult with the easy, and all with a glad and cheerful heart at all times. You have observed that your duties as a nurse are not only to carry out explicitly, accurately and immediately all orders and instructions in the care of the patient as given by the doctor in charge; and the routine as laid down by the hospital authorities; but in addition you must minister subconsciously from your own being, through your personality, something which has a substantial part in the care of the patient—bringing in particular mental comfort and happiness. This can be done by a personality clothed with qualities as already mentioned.

"You have learned what industry means and have practised it throughout your training. You have learned what a life of service means, and have exemplified it throughout your career while training. You have come through trying moments when judgment and responsibility weighed heavily on you; but all this has only tended to make your natures softer, more refined and broadened in perspective.

"In leaving your grand old training school and Alma Mater, do not forget all this as you go forth into the world and enter fields of ever-broadening service. It may be private nursing, public health, teaching or hospital administration. Grasp the opportunities that are presented and always measure up to your undertakings by keen application and by giving the best service in you possible for that particular work. Many of you, indeed perhaps all of you, have undiscovered latent abilities awaiting the opportunity to be developed. Do not cease to advance your knowledge and practical experience by reading, by observation and by post-graduate study. And finally, remember your opportunity for real service to needful humanity when skill with kindness, sympathy and mental comfort is needed.

"In your new fields of endeavor I wish you every good thing that is possible and hope that you will never forget your old training school and Alma Mater who will always stand back of you ready to help you at any time, and who will ever keep a watchful eye over you in your future career.

"And finally, let me charge you to always keep in mind that whenever or wherever there is life to be tended, nursed or cared for, whether that life be yet unborn or newborn, young or old, regardless of social status, race, color or creed, there is the field for the noblest of womanhood exercising the great function of nursing, a profession unsurpassed in opportunity for service and consequent satisfaction in endeavor, by providing means of utilizing science and goodwill to make life worth living for every man, woman and child."

A very unique feature of the evening was the presentation to Dr. MacEachern of a copy of the London *Lancet* one hundred years old. Dr. Blanchard, in presenting this, said: "Some time ago Mrs. Thomas Adams, a former resident of Lindsay for many years, gave me this one-hundred-year-old copy of the *Lancet* to be presented to the first distinguished physician who visited Lindsay. As you (Dr. MacEachern) fill that bill, I am going to present it to you."

On the conclusion of the programme a vote of thanks was moved by Dr. White, seconded by Mr. L. V. O'Connor, highly applauded by the audience and tendered by the chairman, Mr. J. D. Flavelle, to Dr. MacEachern.

Following the programme a reception was held at the home of Dr. Blanchard, in honor of the graduating class.

While in Lindsay Dr. MacEachern was the guest of the Hospital Board. During the morning he made an extensive tour and inspection of the Ross Memorial Hospital in company with the chairman and secretary. After this he, with the doctors of the town, were guests of the Board at luncheon at the Benson House, at noon.

EXTENSION TO STE. JUSTINE'S HOSPITAL MONTREAL

Ste. Justine's Hospital, 1879 St. Denis Street, Montreal, was opened for inspection, under the direction of Mrs. E. P. Benoit, wife of Dr. E. P. Benoit, president of the hospital. A new wing has been added, making it possible to accommodate more than 150 children, where eighty were previously taken care of. The cost of the new building was \$300,000, which is \$170,000

more than was raised in the campaign of 1920. Another important feature of the building is the dispensary quarters on the main floor. Large numbers of the children can be brought every morning for attention and treated and then allowed to remain for a short time in the dormitory which has been provided. Dental rooms and quarters for surgical operations, such as for tonsils, and other throat diseases are also located on the main floor. Twenty-one private wards have been set apart on the second floor and operating cases are located on the third floor. The fourth and fifth stories are reserved for nurses' quarters. Large open verandahs on each floor above the second make it possible for the children to be wheeled out into the sunshine and fresh air. Bishop Gauthier gave the benediction for the formal opening of the Hospital.

FIRE IN UNIVERSITÉ DE MONTREAL

Another fire broke out in the Université de Montreal on November 14th, and the loss is estimated at about \$300,000. This is very much to be regretted, as the reconstruction work of the building had just about been completed since the fire in 1919. The fire broke out in the top floor of the building, which was used by the anatomical, pathological and biological departments and included an up-to-date chemical department. A number of the directors of the Université were at the fire soon after its discovery and discussed the extent of the damage and the work which the reconstruction of the twice-damaged building will entail. There had been a meeting of veterinary surgeons the evening before and they stated there was no sign of fire when they left the building at 9.30 p.m. By a freak of chance the body of the French-Canadian giant, Beaupre, which has been in the possession of the Université for several years, and which escaped cremation in the fire of 1919, again came through the flames untouched.

BYRON SANITARIUM

A session in tuberculosis was held at the Byron Sanitarium on Tuesday, October 3rd, the programme consisting of demonstrations dealing largely with diagnosis by Dr. F. H. Pratten and staff.

QUEBEC HOSPITALS

Hospital service to the public in Quebec has shown a marked advance in the past year, according to the fourth annual report of the American College of Surgeons issued. The report is based on a survey which includes personal visits to each hospital of fifty beds or over in the United States and Canada. The following hospitals were given a place on the "approved" list: Children's Memorial Hospital, Montreal; General de St. Vincent Hospital, Sherbrooke; Hotel Dieu, Montreal; Jeffrey Hale's Hospital, Quebec; Montreal General Hospital, Montreal; Montreal Maternity Hospital, Montreal; Notre Dame Hospital, Montreal; Royal Victoria Hospital, Montreal; Ste. Justine pour Les Enfants, Montreal; Sherbrooke Hospital, Sherbrooke; and Western Hospital, Montreal. The last two hospitals named have instituted measures which ensure scientific medical care to their patients, but have not realized them to the fullest extent to date. For the first time this year hospitals of fifty-bed capacity and upwards have been surveyed. These institutions in Montreal and Quebec show a marked improvement and place Quebec in the forefront of states who are active in medical progress. Quebec is to be congratulated on its splendid showing and on its medical men; and its hospital superintendents and trustees who have made this advance possible.

HOSPITAL BUILDINGS RAZED BY BIG BLAZE

Fire which is supposed to have originated in the power plant in Sydenham Military Hospital, Kingston, on January 3rd, swept the power and heating plant, the canteen and billiard rooms, part of the office department, the gymnasium and the Vetcraft building, leaving them smoking ruins. No one of the one hundred and thirty inmates or staff of about fifty nurses and attendants was in danger at any time, though five nursing sisters, whose sleeping quarters were in the Vetcraft building, were forced to make hasty exits.

The fire for a time threatened one of the hospital buildings. Volunteers hastily removed the contents from this building, and the efforts of the firemen saved it.

Of the one hundred and thirty patients in the hospital, about ten were more or less confined to their beds, but they were not in danger, as their sleeping quarters were not threatened till later on, and the patients were removed to other quarters temporarily, and later still were taken to Mowat Hospital or to Ontario Hall in the city buildings, which were immediately placed at the disposal of the hospital authorities by the corporation.

The destruction of the power house cuts off the heating plant, and all the other patients, as well as the staff and nurses and attendants, are being provided for at the General Hospital, the Hotel Dieu and the Mowat Hospitals, and in the city buildings.

The damage will not be estimated until an investigation is held.

Book Reviews

Feeding, Diet and the General Care of Children. A Book for mothers and trained nurses by Albert J. Bell, A.B., M.D., Assistant Professor of Pediatrics in the Medical Department of the University of Cincinnati. Illustrated. Philadelphia: F. A. Davis Company, publishers, 1923. Price \$2.00 net.

Just what the general practitioner, mother, nurse and medical student need. The "why" and the "wherefore" are emphatically explained. Every effort is made to impress the principles for the prevention of disease. Stress is laid on the relation of food to the teeth. Sample diets for the first twelve years of life are given. Four-hour feedings for infants are strongly advocated. A fine little up-to-date work, supplying a real need.

Nursing in Diseases of the Eye, Ear, Nose and Throat, by the Committee on Nurses of the Manhattan Eye, Ear, and Throat Hospital, New York City. Third edition thoroughly revised. Illustrated. Philadelphia and London: The W. B. Saunders Company. 1922. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. Price \$2.25 net.

This work should serve as a practical guide for nurses in the management of eye, ear, nose and throat cases. The subject is fully covered, clear and definite instructions given throughout, and the volume is well illustrated. This work should prove to be a most useful text book for the nursing profession, and is adapted for both classroom and post-graduate study.

The Doctor in War, by Woods Hutchinson, M.D. With illustrations. Boston and New York: Houghton Mifflin Co., 1918.

This is a book of special interest to physicians. The author is a doctor of high reputation and as a result of his having spent a considerable time in the front lines, he speaks with authority. The volume is divided into twenty-five chapters and is freely illustrated. Some of the chapters have such titles as: The Triumph of the Doctor; The Superb Health of the Armies; A Day in a French Field Hospital; The Risks of a Red Cross Nurse; Healing the Wounds of War; The Drinking Water of the Soldier; The new Diseases of the War, etc. Even to the army surgeon, who went through hell itself with his Division, the book will be most fascinating.

The Breaking Point, by Mary Roberts Rinehart. New York: George H. Doran Company.

This is one of the most attractive stories we have read in quite some time. It will help to wile away a winter evening or too, so, as our friends the Yankees say, "Go get it."

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This preparation consists of the best pharmaceutical extract of malt, neutralized with 1% potassium carbonate, according to the formula of Dr. Keller, and concentrated by a process which preserves the digestive enzymes, diastase and peptase of the malt.

It contains approximately: maltose 61.5%; dextrin 12%; protein 6.5%; ash 2.3%; and moisture 17.7%.

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Hicks' clinical thermometers are now obtained through druggists' and physician-supply houses. W. Lloyd Wood, Limited, Toronto, are the Canadian agents.

CASH'S WOVEN NAME TAPES

If statistics could be compiled of the actual money loss sustained each year by institutions, households and individuals through the laundries, they would without a doubt be quite as astonishing as fire losses.

In addition to the actual loss of clothing there is the substitution of inferior pieces for good, and the ruining of clothes through ink markings. These weird, mysterious marks and cross marks gather and grow on the edges of towels, sheets, pillow slips and table linen until finally one resigns oneself to the black or blue "hen-track" border as inevitable if one is to send clothing to the laundry.

The individual name, woven into fine cambric tape in navy, red, or black, and sewn onto or into every flat piece of individual garment, not only brings the clothing back from the laundry, but it prevents the laundry from marking the clothing with their smudgy India ink.

Cash's Woven Name Tapes are dainty, clear, easily attached and they last for the life of the garment or longer. A gross of them does not cost as much as a single garment which must be replaced.

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Probably the reason for the easy digestibility of the fat and casein content of ice cream as compared with the same substance in the form of milk is that the freezing process prevents the coagulation which usually occurs after milk has been taken into the stomach. The infinitesimal particles remain separated, and are thus easily dissolved by the gastric juices, whereas milk, as we know, may form into lumps, either large or small, and these lumps are difficult of digestion.

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The consumption of ice cream is in its infancy, for as the public learn—as it gradually will learn—of the exceedingly wholesome properties of ice cream and its comparative low cost when its food value is considered, the consumption of ice cream will increase tremendously.

TOO MANY DIPHTHERIA PATIENTS DIE

Why should there be any diphtheria mortality at all? Antitoxin is to this disease what water is to fire. The answer to the question is, therefore, that the antitoxin is not given soon enough or in sufficient quantity. Fire does not spread more surely or more rapidly among combustible materials than diphtheria in the tissues of the child attacked. The one supreme necessity is to head it off—put it out. A dose of 5,000 units of antitoxin may or may not suffice. This dose should be the minimum; and it is far better to give 10,000 or 20,000 units in one dose than in two.

Nature is helpless in many of these cases; her defensive forces are simply overwhelmed by the poison of the disease. Give the patient a full dose, a liberal dose, of antitoxin, and as many as may be required; arrest the poisoning process; and then nature, relieved, rallies her phagocytic forces and destroys the invading bacilli.

The mortality of diphtheria in this country, according to the Parke, Davis & Co. advertisement elsewhere in this issue, is ten per cent. One patient out of ten dies. Save the tenth child!



DR. SENIOR: "Doctor, do you remember that old lady with the indolent leg ulcer I took you to see about three months ago?"

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DR. JUNIOR: "I presume it took many a can of your favorite 'cataplasma' to effect a cure—"

DR. SENIOR: "You mean Antiphlogistine—"

DR. JUNIOR: "Of course. What else?"

DR. SENIOR: "When you have practised medicine as long as I have—and have seen the variety of cases benefited by Antiphlogistine—"

DR. JUNIOR: "Oh, I'm for it too, Doctor, strong."

DR. SENIOR: "I kept right on applying the remedy as hot as the old lady could bear it, and it so stimulated the circulation that new cells were formed—infestation dissipated—tissue repair went on until the ulcer was entirely healed."

DR. JUNIOR: "Well, I can't see why she should be—'kicking'."

DR. SENIOR: "Oh, she's kicking at the size of my bill!"

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Resistance to infecting organisms is really a problem of immunity. Many a person may enjoy the best of health and yet have a low resistance to certain kinds of disease germs. If an affection by such organisms should take place, violent acute diseases are liable to develop or if a sufficient immunizing resistance does not develop, the infection may become chronic. All cases of bronchial asthma are a sequence to attacks of bronchitis in which not enough immunizing resistance developed to entirely overcome the bronchial infection.

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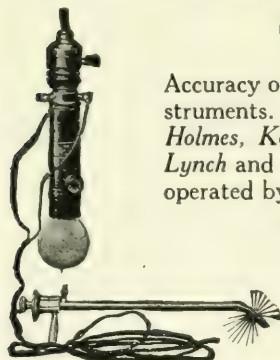
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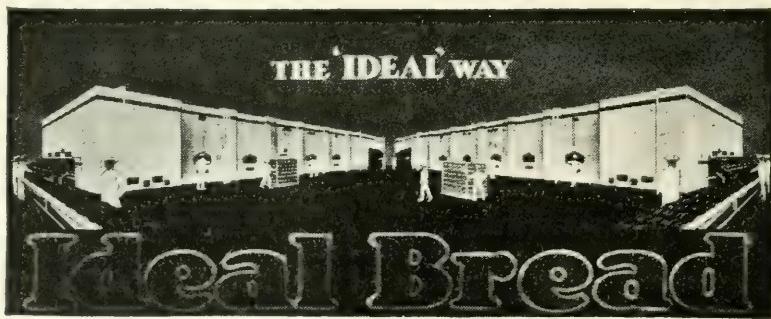
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THE HOSPITAL WORLD

Vol. XXIII

Toronto, April, 1923

No. 4

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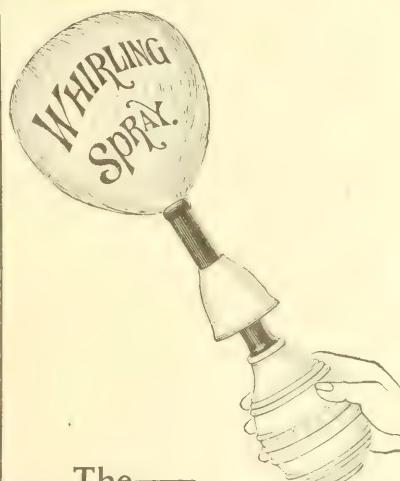
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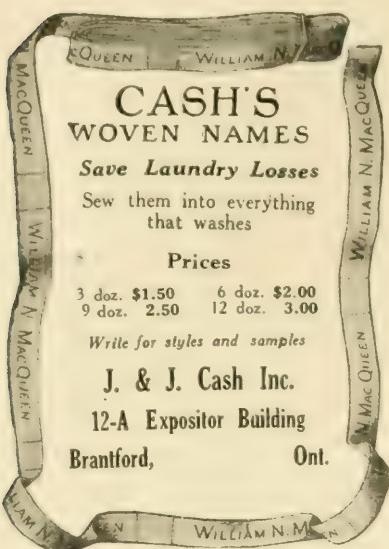
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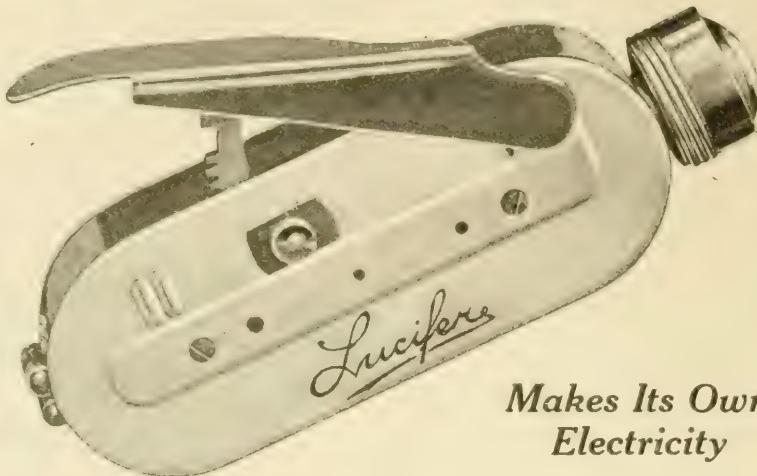
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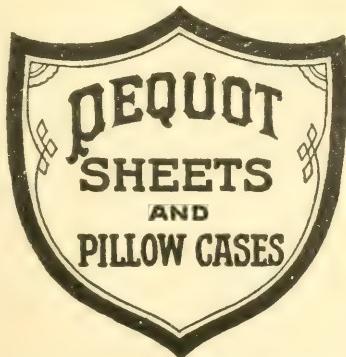
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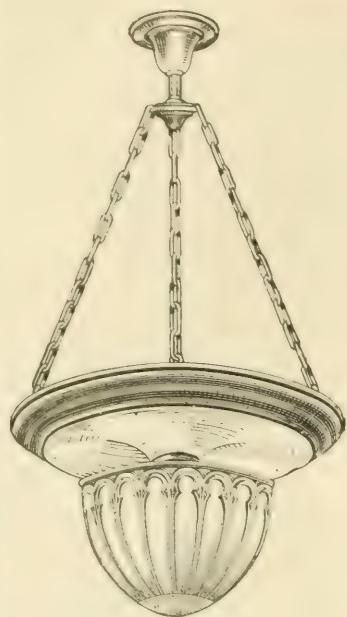
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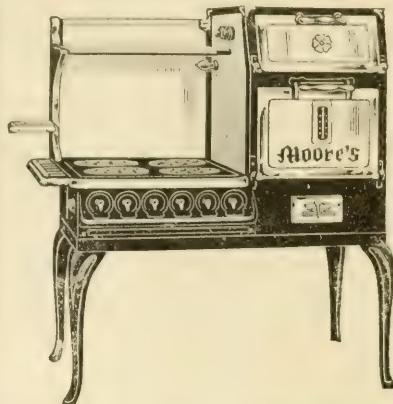
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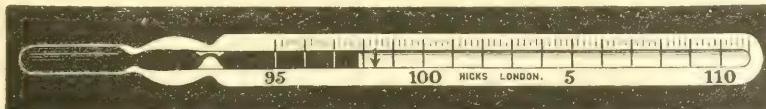
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The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire.

Vol. XXIII

TORONTO, APRIL, 1923

No 4

Editorial

A Journalistic Loss

Miss Charlotte Aikens has resigned the editorship of *The Trained Nurse*, which she filled so acceptably for eleven years. Of Miss Aikens, Canadians have a right to be proud. Educated at the Ontario public schools and at Alma College, St. Thomas, Miss Aikens trained at the Stratford City Hospital, taking post-graduate work at the Poly clinic, New York.

Since 1902 Miss Aikens has been doing hospital and nursing journalistic work. She has published several fine works on nursing, which have had a wide sale. Miss Aikens is full of her subject and is able to concisely and clearly express herself. She has been a most enthusiastic supporter of the American Hospital Association, and has had considerable to do with the moulding of its policies.

In 1912 she was chairman of the committee of the association, on the grading and classification of nurses. *The Trained Nurse* says she attempted a thorough analysis of the situation. The final report of her committee, that organ says, perhaps laid insufficient emphasis upon the function and scope of the public health nurse, but it enunciated many principles which are gradually being put into legislative form, including the following:—

- (1) That all training schools be registered.
- (2) That all nurses, in order to practise their profession as trained nurses, be required to register.
- (3) That the terms "Registered," "Graduate," "Trained," "Certified" and "Professional," as applied to nurses, be limited to those receiving training in hospitals complying with reasonable standards.
- (4) That reciprocity be arranged between states and provinces.
- (5) That supplementary training be planned for nurses who are needed in the care of tuberculous, nervous and mental, contagious and other patients, and that special nurses be required to cover at least one year of training in a general hospital.
- (6) That means be used to strengthen the training schools in small or isolated communities with a view to providing adequate community service.
- (7) That plans be made to secure adequate distribution of the nurses available, preferably in state units, and that greater nursing forces be made available through the encouragement of undergrad-

uate nurses in the completion of their courses—during their stay in the training school or after they have withdrawn.

(8) That the situation be still further improved by the utilization of nursing aides trained to meet the needs of the community and supervised through service centres.

Some three years ago, Miss Aikens made a survey of the leading hospitals of South America. The story of her trip interested and instructed many readers of her journal.

Miss Aikens was one of the organizers and trustees of the Detroit Home Nursing Association, which, under the able superintendency of Miss Agnes Carson, demonstrated how independent people of moderate means could secure adequate nursing at rates they were able to pay, through the co-operation of trained and practical nurses.

Miss Aikens is an ardent Sunday school and church worker. Her brother is one of the leading Canadian divines.

Miss Aikens lives in Detroit, the wonder city of the west—the city of live wires, and efficiency experts. She has a lovely home and, although unmarried, has a most interesting foster family, whose education she is successfully supervising.

We wish Miss Aikens long years of happiness, and hope *The Trained Nurse* will secure an editor, who will not only be able to fill her boots, but her hat as well.

Diabetes

The discovery of insulin by Banting has awakened great interest all over the English-speaking world, but particularly in Canada; in Toronto, very particularly, owing to the over-publicity given to the discovery in the lay press.

Dr. Banting is the most modest of men, and to hear him, (as the writer did the other night), one would suppose that all the work was done by the other fellows and the credit due to certain higher-ups who looked on.

Cammidge and others in a recent *Lancet* cannot be said to boom Banting, nor the insulin treatment, when they say:

"Although the extract of the islands of Langerhans, named 'insulin' prepared and experimented with by workers in Macleod's laboratory recently, has no doubt certain advantages over similar preparations previously employed, it suffers from the same disabilities of only having a brief and temporary effect on food tolerance and requiring to be injected intravenously or subcutaneously, oral or rectal administration having been found useless. It seems unlikely, therefore, that this method will prove of great clinical value, excepting in emergencies where it is necessary to tide the patient over a crisis."

The ordinary practitioner, in reading the various recent articles on Diabetes may feel somewhat abashed when a patient comes to him with glycosuria or diabetes mellitus, on account of the frequent elaborate chemical investigations on blood and urine, which seem necessary in the investigation and treatment of such a patient. He ought not to be; he should try his hand on it, rather than turn it over to some one else.

To treat a patient intelligently, the practitioner should provide himself with certain books—certain simple laboratory glassware and a few reagents. The books should comprise, say, "The Starvation Treatment of Diabetes," by Hill and Eckman (W. M. Leonard, Boston, Mass.) which contains a description of the ordinary tests; and "A Dietary Computer," by Amy Pope (Putnam Sons, New York). If he wishes, he may also buy Joslin's primer or the primer by Wilder, and others of the Mayo Clinic, (W. B. Saunders Co., Philadelphia).

One may use his every-day Fehling test for sugar, or the more delicate Benedict, formula of which may be taken from one of the forenamed little books. To get at the quantity of sugar, he may use the fermentation test (see Hill and Eckman's book), or he may use Carwardine's saccharometer, which he can carry to the bedside or home kitchen and in five minutes make a quantitative test. The writer has found this apparatus very useful. It is made by Archibald Young and Son, 57 Forrest Road, Edinburgh.

The Allen starvation treatment is described so specifically and clearly by Hill and Eckman that any practitioner will be able to prescribe it easily.

Care must be taken to examine the urine twice daily, for sugar, acetone and diacetic acid, until one feels all danger from ketosis or hypoglycemia are past. Complete 24-hour specimens should be secured for one of the daily analyses.

A little study and assistance from the doctor will enable the ordinarily intelligent housewife to manage the diets. A weigh scale is considered essential, but by reference to the diet lists given in the small books, a measurer equivalent to the stipulated weights is indicated, so that the poorer patients, perhaps, may be handled without having to pay \$16.00, the price asked by the dealers for a diabetic food balance. To be sure, a simpler balance may be secured with the avoirdupois weights. In such case the food dispenser must be taught to translate metric-weights and measurements into avoirdupois.

The above applies more particularly to the treatment of the early cases. But we believe, after the practitioner has tried out the above treatment in the less severe cases, he will be encouraged to enlarge his laboratory equipment to enable him to make estimations of blood sugar and the like, and tackle the more severe type of the malady.

Commitment of Insane

While the Ontario Government is considering the erection of another asylum to accommodate the increased number of patients, public attention is being focussed on the lax method of commitment of alleged insane persons. It is being openly asserted that many of those so committed are not strictly insane, but are the helpless victims of an interested relation plus the concurrence of two compliant physicians, following a much too hasty medical examination.

In spite of the present day vogue of psychotherapy as an active factor in medical treatment, and the vastly enlarged mental variant thereby revealed, it is rather surprising that no corresponding advanced step has been taken by the state regarding compulsory asylum commitment.

Without entering into the question of private motive in dealing with individual cases, it is pertinent to ask whether the patient gets a fair showing in the short time and necessarily brief observation permitted by the law preceding commitment.

In Ontario, forty-eight hours is the time limit allowed for medical men to make definite pronouncement concerning a patient's sanity, and to place upon him the indelible mark of compulsory confinement within asylum walls. In Quebec province the commitment may take place immediately.

The State of New York does better than Canada. The law fixes ten days as the limit in which to determine whether a person is insane or not. Yet the New York Commissioner of Public Welfare says: "There should be a change in the law allowing patients to be held such a period of time as the doctors may think necessary. From my own study of this matter, and it has been very intense, I believe from twenty to thirty per cent. of the people now sent to insane asylums need not go."

As a result of this protest, there is now in New York a strong movement to arrange for such legislation as will give any unfortunate charged with insanity as much chance for freedom as that given to an ordinary criminal.

Psychiatry is not an exact science; it is only on the threshold of its own dim and shadowy territory, which in present development is not to be defined by fixed boundary lines. Therefore, the authority to pronounce a person insane to the extent of depriving him of his liberty, should be most carefully guarded by legislation. As Dr. Coler says, "The proper handling of the subject to my mind is one of the most important matters before the people to-day."

Nurses and Tuberculosis

Dr. Stewart, acknowledged as an outstanding tuberculosis expert, says that we have medical men going out into the practice of medicine, and nurses going out to nurse (trained in general hospitals for the most part), with practically no knowledge of a disease which is responsible for one death in ten. "Do you think," he said to a gathering of hospital workers in Winnipeg recently, "that it would be right for doctors and nurses to go out and practise medicine without a knowledge of typhoid fever?"

Dr Stewart went further: "not only do nurses know very little about tuberculosis, but what they know, they know wrong." This was not the fault of the doctors. A general hospital could not teach tuberculosis; it must be done in a hospital devoted to tuberculosis. Some nurses were frightened to go among the tuberculous. "There is no nursing staff in any country which has been freer from

tuberculosis than the staffs of sanatoriums treating tuberculosis," declared Dr. Stewart. "There have been many more suspicions among nurses who graduate in Manitoba hospitals than at the Ninette Sanitarium. For fifty years there have been sanatoriums for the treatment of tuberculosis and there is no case of a nurse who has contracted it from nursing in sanatoriums.

"Nurses in tuberculosis hospitals are learning how to treat chronic and convalescing patients."

Dr. Stewart would welcome the undergraduate nurses from all of the Manitoba general hospitals if they came regularly.

It is time all nurses training in general hospitals had at least six weeks' experience in a tuberculosis sanitarium, unless they receive such training in a general hospital which treats cases of pulmonary tuberculosis.

CORRECTION.

We gladly accede to the request of Dr. H. R. Smith, medical superintendent, Royal Alexandra Hospital, Edmonton, who writes to make a correction in the figures which appeared on page 64 of the February number of this journal, reading as follows:

"Now, we found out at our hospital that the graduating class of twenty nurses cost us over and above anything they rendered the hospital, \$1,000 per nurse. In other words, by the time a class of twenty nurses got through the hospital they were indebted to the hospital to approximately \$20,000."

These figures should be: "cost us over and above anything they rendered the hospital \$500.00 per nurse" and "they were indebted to the hospital to approximately \$10,000."

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

The official organ of The Canadian Hospital Association, The Alberta Hospital Association and The British Columbia Hospital Association.

Editors:

ALEXANDER MacKAY, M.D., Inspector of Hospitals, Province of Ontario.

JOHN N. E. BROWN, M.B. (Tor.), Ex-Sec'y American and Canadian Hospital Associations, Former Supt. Toronto General and Detroit General Hospitals.

M. T. MacEACHERN, M.D., Director-General, Victorian Order of Nurses, Ottawa.
W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont., Consultant, Toronto Hospital for Incurables.
MAUDE A. PERRY, B.S., Supervising Dietitian, Montreal General Hospital

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Original Contribution

ADDRESS*: DR. ARCHER, Lacombe, Alberta.

It is a very great honor and privilege to address you to-night as representative of the Alberta Medical Association. It is obviously my privilege at this late hour to leave out a considerable part of what I had intended to say to you. There are a few things I wish very much to say on behalf of the Medical Association, and I am going to try and say them very briefly, leaving out much of the material which I had prepared. I want to make a few remarks in order that we may see and remember to-night some of the changes which have occurred in matters relating to public health, not only in this Province, but in the world, as a result of the activities in medical science in the years which have passed.

Let us think for the moment of the smallpox. In 1888 Osler stated that the death rate from smallpox was 25%. We realize that there was a very great deal more smallpox at that time than this; this as a result of a fairly universal use of vaccination. There was an epidemic in the city of Philadelphia seven or eight years ago, and of the unvaccinated there were 2,800 with 1,500 deaths. Now that gave the higher death rate of 44%. In the vaccinated cases there were 2,100 with just 28 deaths or a little over one per cent, and then as we saw the smallpox it was in a largely attenuated form. Going to the case of diphtheria a few figures: in Boston in 1888 to 1894 the average death rate was 44%. Antitoxin was then introduced and the death rate fell to 15% in the succeeding ten years, and in 6,080 recent cases the death rate was only 7%, a drop from 40% to 70% in some instances over a period of a few years after the use of antitoxin. In 1920 in this

*Read at the Convention of the Alberta Hospital Association, and the Alberta Association of Registered Nurses.

Province there were 608 cases of diphtheria with 82 deaths or about 13%. In the city of Edmonton there were 284 cases with a death rate of 7% and that leaves a death rate to the rest of the Province of 19%, and because it is so very remarkable I wanted to give it to you in public meeting to-night, because we want everyone to realize that we are getting the death rate from diphtheria reduced to a small minimum and that is by giving antitoxin early in the disease. In a city like Edmonton the case is seen early and the death rate is small. In the rest of the Province—I am not referring to the vicinity that Calgary is in because, as it happens, there were very few cases in Calgary that particular year, so the rest of the cases occurred largely in the rural districts, and not being seen early the death rate was about 19% against 7% where the cases were seen comparatively early.

Take tetanus, or lockjaw, which was a terrible plague. In 1903 there were 406 deaths from lockjaw, but since the use of the serum in 1909 the number dropped to 150; in 1910, to 78; in 1911, to 18; in 1912 to 7 deaths in the whole of the United States from lockjaw as a result of the use of this prophylactic serum. In the first year of the war the results were very unfortunate, and a good many cases affected the wounded until a uniform habit was adopted of inoculating all wounded men, and after the first three months it almost disappeared as a cause of death in wounded men.

Typhoid fever with a death rate given in the Indian Medical Service as 25% in 1899; with the use of a protective vaccine in the army, commencing long previous to the war, the number of cases of typhoid were very few and the death rate became very small. The same experience was proven in the recent war. The waste in the South African war from typhoid was a very prevalent cause of death among the soldiers. Typhoid fever is invariably checked by the inoculation of the men with typhoid vaccine, and yet, in this city not very long ago, to a great audience and with a good deal of applause, a speaker ridiculed the idea of what he called the "germ theory" of disease. It is all based on fact, and yet people still talk of the germ theory of disease, and I have

something to say about the responsibility of the medical men to the whole community which I do not think they have lived up to. I think that the whole community is not cognizant with some of these facts, lies at the door of the medical profession.

Referring to the surgical side and the development that has occurred, I would like you to think of one picture in the life of Lister. About 75 years ago the great Scotch surgeon was operating and it was the first time that anesthetic had been used in England. It had been used in the United States and was known as a "Yankee dodge for making people insensible." At that time operations were largely limited to amputations. There were no abdominal operations being done before the days of Lister, who introduced the use of carbolic acid. In this room where the operation was performed the floor was covered with sawdust, and I think that was a very realistic touch; the students were standing around and Lister came in dressed in an old frock coat with his sleeves rolled up, and told them he was going to try this "Yankee Dodge." At that time speed was the essence of skill. At that time operations were done with a man fully conscious, and one thing necessary was the man with the stop watch, and his student was present with the stop watch to keep time. At this particular time after the man had received the anesthetic the time was 47 seconds; he had amputated the leg in the middle of the thigh. In those days the wound was not closed, because all wounds were not closed, just the bleeding points tied up. They could not close them because all wounds were infected, so they were left open to drain well. Now that is one picture.

Then there is the familiar picture in "Rab and his friends," but in these days that dramatic situation could hardly be possible because the dog would not be allowed in the operating room. That operation was performed by Symes, who was a contemporary of Lister. Those things were only seventy-five years ago, and those familiar with operating-room technique of to-day can realize what a long way we have gone. It is not very many years since abdominal operations first began. The most familiar friend of all, I suppose, is

the removal of the appendix, and it was only in 1877 that the first operation for the removal of the appendix was performed. Sir Frederick Tree and Norton, of Boston each removed an appendix, one in the year 1877, and this year in a medical meeting, the gentleman who was delivering the address said that he remembered his Professor in Anatomy saying, "This is the appendix; it is not interesting, because it is a vestigial organ which has no function and no disease."

Now I want to mention two only of the phases which have developed of recent years, and upon which great emphasis is being laid in modern medical science. The first I wish to speak about is the great stress which is being laid to-day upon the necessity for accuracy in diagnosis. It seems with us in the medical fraternity that it is absolutely fundamentally important. It is obviously necessary to find out the trouble and to locate that, it is absolutely necessary there shall be a correct diagnosis. Take the illustration of the appendix once more. We must realize, most of us, how very frequent and how much dreaded, inflammation of the bowels was a few years ago. A doctor forty years ago was satisfied with making a diagnosis of inflammation of the bowels. The doctor to-day is not satisfied until he has found what has caused that peritonitis, and he is not satisfied with knowing what particular organ in the abdomen is causing that; he wants to know at what particular time that particular organ got into trouble and so he goes back; is it an infected tonsil, infected pyles? There is usually some infection still farther back, and I am going to take that one illustration to show how the art of diagnosis is going back farther and farther trying to get these facts on an absolutely firm foundation, so it will be possible for the medical man to know what causes that condition. There was a time when the doctor went into the house and the evidence of his skill was that he could, without ever examining the patient at all, without history of the sickness, immediately tell what the trouble was. Maybe there are some medical men so skilled still living; I have never met them and we do not think such a medical man would claim to-day to be scientific because he knows such a claim is absolutely impossible. When we think of the many aids to diagnosis which

are necessary; the worth of chemistry, the many forms of complicated and technical examination which are necessary to enable the medical man to establish a firm knowledge as to what the particular trouble with his patient may be, then we realize we have reached a long way towards scientific knowledge of disease. We have not got to the end of the road. A great deal of the spice of practice is in the continual increase of knowledge which we make from day to day. What does this mean? It means that the whole of the subject of the investigation of disease in any particular individual is too complicated to be completely done by any one man. It is no longer a one man job; that is, an isolated individual cannot in all cases establish absolutely a correct diagnosis. These various branches of the work are so technical that many have to specialize; they have to perfect themselves in these particular lines of investigation and treatment, and so we come to the other point in the development of modern medical science, and that is the tendency towards specialization.

There has been the tendency to make considerable mirth over the tendency to specialize. I am not going to say anything more about it at the present.

Now I think also there is a certain amount of confusion in the minds of the public and the medical men owe it to the public to do all in their power to set the public straight in their thought of the various specialties, and owe it to the public to call to their aid their colleagues, the specialists in certain types of work, because no one man is in a position to do all that may be done for all cases to-day. If these things are true what shall we do in this Province? What may be done in this Province to enable the profession to meet the responsibility which is before them? I realize that the medical profession have two responsibilities, two types of responsibility. One is for the establishing of a diagnosis and treatment, and the other is for the dissemination of knowledge with regard to the care and prevention of disease and the maintenance of health. With regard to the first I think the medical men are doing conscientiously day by day their utmost. With regard to the second I do not feel the medical men have lived up to their opportunity. Do you realize in

the Province of Alberta in 1920, there were 139 women died from childbirth, and that there were over 1,000 babies died, 411 still births. I am just mentioning these figures. The death rate of babies in one year was 93 in 1,000; in 1920, which is only a few years ago, the percentage was 140 in 1,000. The death rate in sunny Alberta, where there is lots of fresh air and lots of fresh milk, is larger than in the number of American cities with slum conditions and difficulty in getting pure milk. The death rate, through lack of knowledge, is larger than in many of the large American cities.

There is one thing the medical men are planning to do with the co-operation of many organizations, and I want to draw your attention to it. This fall they are planning to put on a public health week in this Province, and it is for the purpose primarily of fulfilling this second responsibility that I speak. I think the Medical Association feels they have not lived up to their whole responsibility to the public for the dissemination of knowledge for the care of certain diseases and for the prevention of other diseases and of the maintenance of the public health of the Province, and this public health week, with the co-operation of the other Associations—and a number have signified their desire to co-operate and help—will take up such subjects as tuberculosis, venereal disease, child welfare, and give a great deal of publicity, all that is possible for them to obtain, to disseminate information along that line.

I am very glad the Minister is here to hear these assurances because I know he is interested in this particular phase of our Medical Association, taking steps to put at the disposal of any organization in the Province all the speakers on this same subject at any time that an organization anywhere in the Province may require such service. We are trying to measure up to this responsibility. We realize it is a very vital question and we want to supply information and to help to still further improve the health conditions of this Province.

Just this one other word. If in these complicated conditions where diagnosis is difficult and where treatment is specialized, if we are going to be able to give that kind of diagnosis and that kind of treatment all over the Province

where there are so many people living with very few doctors, for 264 doctors in this Province are in the four larger cities, and 262 doctors are in the rest of the Province and now, if we are going to be able to meet the needs, the health needs of the rest of the Province, it is only by there being a health centre and by a health centre I mean the hospital. The institution of the municipal hospital system must come if this problem is to be satisfactorily solved. Dr. Stanley will have something more to say along that line, with the municipal hospital extending in smaller units if necessary, to make a weak district to get into line to have a hospital with two or three nurses and a doctor. Let a little group grow up around these institutions, not to do largely specialized work, but to work efficiently and well around one of these hospitals. This is an ideal for which we must hope and struggle. I thank you.

HOSPITAL DIETETICS

MISS MAUDE A. PERRY.

SUPERVISING DIETITIAN, MONTREAL GENERAL HOSPITAL.

In the organization of a department of dietetics in any hospital, large or small, a knowledge of the real meaning of dietetics is essential. It is the science of correctly feeding an individual or a group of individuals, in sickness or in health. From this, it may readily be seen that the field of work of a dietary department of any hospital is a broad one. While one never loses sight of the fact that the primary purpose of the hospital is the care of the sick, hospital superintendents and everyone interested in the management and upkeep of these institutions know that this is only one phase of the work of their hospitals. Likewise, the feeding of hospital patients is only one of the duties of the dietary department.

A properly organized department of dietetics should control everything that has anything to do with the supply, preparation, service, or storage, of all food stuffs used in the hospital. This does not mean that the dietitian shall necessarily personally buy or distribute the foods, but foods should not be bought nor distributed without her approval if she is to be held responsible in any way for these.

I am not going to attempt to outline any plan that would be an invariable standard for the organization of a department of dietetics in all hospitals. I do not believe that any one can do this successfully. Different types of hospitals must be governed in this by their size, purpose, location, financial condition and many other factors.

In many small hospitals, the dietetic department combines the duties of dietitian and housekeeper. This person has charge of kitchens, dining rooms, supplies, and of all help employed in connection with these. In larger institutions where both private and public patients are received, there is a greater diversity of work. If the dietary department is well organized, it supervises public kitchens, diet kitchens, dining rooms, stores, service of food on wards for private and public patients, menu planning, care and renewal of equipment, employment of help; and it has many other duties, not always easily tabulated. This department also teaches both theoretical and practical dietetics to nurses, gives personal attention to special diet cases, and collaborates with physicians who wish to avail themselves of its aid. In hospitals where children are patients it supervises the milk station or prepares the formulated feedings in the diet kitchen.

Anyone who has studied the expenditure of hospital finances knows that a large part of this is incurred through the purchase of food alone. Hence an insistent demand has arisen in the United States and in Canada for well-trained people for the work of the dietary department. The American Dietetic Association, which numbers among its members nearly all of the leading dietitians in Canada, including those engaged in hospital and educational work, realizes the urgency of the need of good training. The members of this association have established standards for training of dietitians which will make it possible for hospitals to obtain competent people if they wish them.

In various parts of Canada, schools, which formerly educated their students for teachers of Domestic Science only, are adding courses of study which are planned for those who wish to do hospital work. Some hospitals are taking these students upon graduation for an internship of six months of

actual hospital training. Many hospitals will not engage a dietitian who has not had this period of training as a pupil dietitian. Surely, it is just as important that a dietitian be well trained for her profession as for a doctor or a nurse, for all three are trained either to be of service to those who are ill or to aid in the prevention of illness.

OTITIS MEDIA COMPLICATING OPERATIONS ON THE CASSERIAN GANGLION

The type of otitis media described by Horace R. Lyons, Rochester, Minn. (*Journal A.M.A.*, Jan. 20, 1923), occurs from a few days to several weeks after operation on the gasserian ganglion. The chief complaint is a sense of fulness and deafness on the side on which the operation is performed. Otalgia is never severe, and is not a common complaint. Examination of the ears discloses a fulness in the inferior quadrants of the tympanic membrane, with more or less obliteration of the common landmarks. There is usually a fluid level, and a bubbling sound is heard with inflation of the eustachian tube. In this condition, there also appear, within the middle ear, bleblike formations without evidence that the remainder of the cavity contains fluid. In one case observed, secretory otitis media followed alcohol injection of the posterior root of the ganglions. Spontaneous rupture and secondary infection, resulting in suppurative otitis media, occurred. It is also of interest that the posterior root was injected since the neuralgia disappeared at once, and cutaneous anesthesia followed. In another case of secretory otitis media, suppuration occurred but cleared up promptly. The author suggests that the condition is probably due to trophic disturbances in the mucous membrane of the middle ear. Trauma, as an etiologic factor, is eliminated so far as the ear is concerned, and this gives further basis for the argument that the corneal complications* are entirely trophic in origin. The process may be similar to that occurring in a herpes zoster oticus.



Selected Articles

LABORATORIES IN SMALL HOSPITALS*

G. F. STRONG, M.D., ASSISTANT SUPERINTENDENT,
VANCOUVER GENERAL HOSPITAL,
VANCOUVER, B.C.

In the past few years the hospitals of our continent have been most thoroughly impressed with the importance of laboratory work, and recognizing this and the many difficulties connected with carrying out the service, I have been prompted to present this brief paper, designed to set forth in as practical a manner as possible the essential minimum laboratory service which should be found in every hospital caring for the sick. It presupposes co-operation between the large and small hospital laboratories, especially in relation to the training of technicians and the performing of certain complicated technique which cannot be carried out in the smaller laboratory.

The laboratory service probably represents our most efficient aid in proper diagnosis, and includes besides the clinical laboratory—the X-ray, the electrocardiograph, the respiration calorimeter and other such instruments. I shall consider only the clinical laboratory and shall outline the requirements of such in a hospital of less than 100 beds. I will try to set forth the fundamental and minimum service which every hospital should give.

MUST HAVE CO-OPERATION.

There are certain essential requirements that any laboratory must fulfil. Its work must be accurate, the clinicians must be able to depend absolutely on the laboratory reports. It must be so organized and maintained that it can report its findings promptly. The service must be accessible to all. The

*From a paper read before the 1921 Convention of the British Columbia Hospital Association.

laboratory depends for its existence on the intelligent use of its facilities by the clinicians. Such use can only come when the clinicians are well acquainted, not only with the laboratory procedures and their constant improvements, but with the technicians who are carrying out these procedures.

The laboratory must be equipped to examine urine. The examination must include the determination of specific gravity and the reaction, the tests for albumin and sugar and the microscopical examination of the sediment. Specific gravity is especially important in certain forms of chronic nephritis in which this factor tends to become fixed. Albumin is most commonly found in nephritis, also it is especially important as an early indication of renal trouble in pregnancy. It is sometimes necessary to determine the amount of albumin excreted. This can be done with a sample from a twenty-four-hour specimen. Sugar is present in a number of conditions. Its continued presence in the urine is usually diagnostic of diabetes mellitus. In some conditions it is desirable to know the amount of sugar excreted each day and this is easily determined.

The nature of the sediment, as determined by microscopical examination, is very helpful in diagnosing acute infections of the kidneys, ureters, and bladder, and the chronic nephritides. The examination of the sediment for tubercle bacilli is the only positive test for tuberculosis of the kidney. Sediment for examination is best collected by centrifuging a freshly void specimen. It may be obtained by allowing the urine to stand for some time, but the centrifuge offers a much quicker and more certain means of collecting all the sediment. There are many cheap and efficient centrifuges on the market, some run by water power, others by electricity, and others by hand.

Of the other than routine tests, the most important is the test for diacetic acid. This substance is important when it can be taken as a sign of acidosis and, in the treatment of diabetes mellitus, it is quite essential that it be tested for daily. One other test that might be demanded in certain cases is the test for bile. Though this is by no means as simple as the previously named test, it may be done in the small laboratory, and the results will occasionally justify the effort.

I do not believe that the other more complicated urine tests, such as the one for urea, diastase, total nitrogen, etc., should be attempted. There are very few cases in which these tests are absolutely necessary for a diagnosis, and in such an event the cases would better be sent to the more fully equipped laboratory centre.

There are the functional renal tests, however, which must not be overlooked. The phenol-sulphonephthalein test is the most important simple test we have to give us an accurate idea of renal function. The technique is extremely simple and the result very valuable. Another functional test that is extremely useful is the Mosenthal test or a modification of it. For the small hospital the simpler technique of the so-called two-hourly test is more apt to be properly carried out and is quite as valuable in its results.

BLOOD EXAMINATIONS.

The first requisite for a blood examination is a technician who can count blood corpuscles with accuracy. The degree of error of such count must not exceed four per cent. Such proficiency can only be attained by practice; for this reason, a non-medical technician who is able and willing to spend a great deal of time at this work is superior to a physician. Next, it is necessary to have a properly standardized hemocytometer and a reliable microscope. The most important test in the majority of cases, is a white and differential count. This is essential in acute surgical conditions, especially those involving the abdomen. The red count and the examination of the red cells in a blood smear to determine any abnormalities of morphology and to detect the presence of any abnormal red cells, is of importance in the anemias, as is also the estimation of the hemoglobin contents of the blood. This latter determination is done in many ways. The simplest, and perhaps the best method for small laboratories, is the so-called Tallquist method; which is also the cheapest means available. For more accurate results, especially in low hemoglobin findings, a more accurate apparatus must be used, such as the Sahli Hemoglobinometer.

A complete blood count, consisting of a red and white count, a differential, an examination of the morphology of the red cells and a determination of the hemoglobin, might well be done as a routine on medical cases. Where time for such a complete examination is not available the following procedure is helpful: It has been found that for practical purposes, if the hemoglobin is above seventy-five per cent. and if the case is not anemia of some form, the red blood cells will always be within normal limits. Also it has been found that in non-acute conditions, if the white cell count is within normal limits, a differential is not necessary. Thus, in many cases, a practically complete blood examination may be performed by determining the hemoglobin and the white cell count. A blood count, when not an aid in making a positive diagnosis, is helpful in ruling out certain diseases. The examination of blood smears for parasites is essential, especially in districts where malaria is encountered.

Blood cultures should not be attempted because proper incubating facilities cannot be installed owing to the relatively large expense. By "relative expense" I mean that in considering laboratory equipment we must consider the use that will be required of such equipment. For example; an incubator can be obtained at less cost than a microscope, but a microscope is absolutely essential and will be used at least once for every hospital case, whereas an incubator might not be needed except for one case in ten. An incubator, then, is relatively more expensive than a microscope. Serological work, including Wasserman tests, Widals, etc., should be handled in the large division laboratories. Blood chemistry is also somewhat too complex to be attempted without a skilled technician specially trained in this work; besides, the apparatus required is too expensive for the small hospital.

BACTERIOLOGICAL EXAMINATIONS.

For the bacteriological work there must be facilities for the examination, microscopically, of sputum and discharges of various kinds. Further than this the small hospital should not attempt to go, as it involves the expense of proper media and incubators. There should be the necessary stains for examining smears for tubercle bacilli, gonococci and the organisms of Vincent's angina.

The pathological work cannot be done in the small hospital on an adequate scale. The surgical pathology should by no means be neglected on this account. Tissue removed at operation on which a pathological diagnosis is required, can be sent to larger institutions for a report by the pathologist. The tissue so sent, if large and thick, should be cut serially into thin slices so that it will be well hardened. If small, as appendices, etc., it should be left intact. This material should be sealed in a small bottle containing a preserving and fixing solution and mailed promptly to the central laboratory. The cost of this service should be met by some flat rate based on the bed capacity of the small hospital.

SPINAL FLUID EXAMINATIONS.

A laboratory of any size must be able to examine spinal fluid—a cell count and the determination of the globulin are the important tests. The Wassermann on the spinal fluid should be done, with the rest of the serological work, in the central laboratory. The cell count is performed by means of the hemocytometer used in blood counting, with the difference in the degree of dilution used. An increased count always indicates inflammation of some kind. In the acute forms of meningitis there is a high count of mostly polymorphnuclear cells; in the chronic forms, tuberculous and syphilitic, there is usually a lower count and the predominating type of cells is the mononuclear. In syphilis of the brain and cord, as well as in syphilitic meningitis, there is an increased cell count. Globulin also usually means inflammation.

EXAMINATION OF STOMACH CONTENTS.

The examination of the stomach contents after a test meal, is frequently very important and should be done more often. The use of this simple test will sometimes obviate the necessity of an X-ray examination, thus saving the patient time and money. This is specially to be remembered in those institutions without an X-ray outfit. The routine examination of stomach contents collected one hour after an Ewald or similar test meal, consists of the determination of the degree of digestion as judged from microscopic appearance; the estimation of the amount of free hydrochloric acid, of the

total acidity, of the presence of lactic acid and of occult blood, and the Boas-Oppler bacilli. These tests are quite easily made and do not require technical skill nor elaborate equipment. The results are valuable, not only in gastric disease but in general disease with some secondary functional or organic gastric disorder.

The examination of feces is so simple as to require a mere mention, and yet it is an invaluable diagnostic aid. The examination should be both macroscopic and microscopic in the search for parasites or their ova. Occult blood may be important in chronic intestinal cases. The presence of unusually large amounts of fat points to some disturbance of the external secretion of the pancreas.

This completes the list of laboratory examinations that may properly be made in the smaller hospital. I have outlined these tests only very briefly, as it has been my intention merely to suggest the possibilities and limitations of the small laboratory rather than discuss laboratory technique. Any small text on laboratory methods will give in detail the above mentioned tests.

CO-OPERATION BETWEEN LABORATORIES.

The small hospital laboratory becomes, then, in a sense, an outlying branch of the large laboratory. The smaller laboratory, as it grows in volume of work, would be able to take more and more of the necessary procedures unto itself, thus finally becoming an independent unit with a complete staff. The plan of large central laboratories co-operating with the smaller hospitals in the execution of the complicated tests, offers a solution to the problem of furnishing proper means for correct diagnosis in the small isolated hospitals. This whole scheme, of course, applies principally to the small hospital in the small city, town and district, where a larger bed capacity is impossible and where facilities should be afforded the clinicians for good work.

As to the means for providing such laboratory service. I am convinced that, wherever possible, the non-medical technician should be employed. In view of the fact that in the larger centres it has been found advantageous to use non-medical workers, it seems to me even more imperative that

this be done in the small hospitals. The objection that the expense of such a technician will be too great must be met. In the hospitals of fifty beds or more, such a technician can be provided who will also look after the case records and the X-ray department. For the smaller hospitals it will frequently be possible to train a ward nurse to perform these simple tests, while at the same time she might carry on some ward work.

The non-medical full-time laboratory worker is, of course, the ideal towards which all hospitals should strive, as it is only when their laboratories are in such hands, directed, naturally, by the physician in charge, that they will achieve the best results. The interpretation of the results of laboratory tests must rest with a graduate in medicine. The technician fit to carry on this sort of work should be trained in one of the large laboratory centres where it is possible to work under the supervision of the highly paid physicians who have specialized in laboratory technique. Technicians having had such training are competent properly to carry out this laboratory technique. Accuracy and speed can only be attained by long practice under proper supervision, and both accuracy and speed are essential in a laboratory technician.

It is not to be expected that graduate physicians can be employed for such work—the remuneration would be too low and the work too mechanical to justify them in such expenditure of time. Technicians for this work can only be properly trained in the larger hospital laboratories, and in this connection I may add that there has been inaugurated a technician's course at the Vancouver General Hospital that will fit a nurse to do the laboratory technique as outlined, also the necessary X-ray work, as well as giving her a fundamental knowledge and experience in connection with medical records, particularly as to obtaining, classifying and filing same. A graduate nurse, after such a course, extending over ten months, during which time she spends two months on records, four months on laboratory work and four months on X-ray work, should be the ideal person to handle these three services which are so essential in all hospitals of to-day.

COST OF LABORATORY SERVICE.

The cost of laboratory service as I have outlined will, of course, vary with the size of the hospital. The minimum initial cost should not be over \$350, which I have itemized in the attached list. The cost of upkeep of the equipment and supplies would be between \$50 and \$60 per year. The salary of the technician would amount to \$100 per month and keep (which would mean \$135 per month). This would bring the total cost per month to about \$140, which amount could be reduced in proportion to the time so spent, if the technician was working part time on records or other services.

The cost might be met in two ways: firstly, by making a charge for each laboratory test; and secondly, by collecting a flat rate of so much from each patient per day. The latter of these is, I believe preferable. The former tends to lay a heavy burden on the few that need a great deal of laboratory work, while the second plan divides the burden so that it is really not felt by anyone, yet it is no injustice because all patients will benefit by the the laboratory service in the hospital. For example: in a hospital averaging fifty cases per day, there are 1,500 treatment days each month; a flat rate of ten cents per day will yield \$150 per month, or more than enough to provide such laboratory service. In those smaller hospitals not maintaining a full-time technician, the cost would be proportionally less.

This, therefore, sets forth, briefly, the fundamental and essential minimum laboratory service which should be found in every hospital desiring to do competent work and to take good care of their patients. From such a basis can be developed a much larger and more highly organized laboratory system as the institution grows in size, till finally, the various departments such as pathology, bacteriology, serology, clinical microscopy, blood chemistry, etc., are organized, having a competent director and staff and giving an efficient maximum service to all hospitals.

List of equipment for laboratory for hospitals of 100 beds or less:

- One gross test tubes, 5x $\frac{5}{8}$, without lip.
- One gross test tubes, 8x1, for urines.

Tincture bottles, xx glass ware, ground glass, stoppered, 12—4-oz.
Tincture bottles, xx glass ware, ground glass, stoppered, 12—6-oz.
Flasks, Erlenmeyer, 4 100 c.c.
Flasks, Erlenmeyer, 4 250 c.c.
Flasks, Erlenmeyer, 4 500 c.c.
Flasks, Erlenmeyer, 2 1,000 c.c.
Three evaporating dishes, diameter 3 inches.
Two pounds assorted glass rod.
Two pounds assorted glass tubing.
Two burettes, Moher Shellbeck, capacity 50 c.c., Grad. 1/10 with pincock.
Pipettes, grad. 1/10 c.c. to tip; 6 1 c.c.
Pipettes, grad. 1/10 c.c. to tip; 4 5 c.c.
Pipettes, grad. 1/10 c.c. to tip; 4 10 c.c.
Pipettes, volumetric, 3 5 c.c.
Pipettes, volumetric, 3 10 c.c.
Pipettes, volumetric, 2 20 c.c.
Pipettes, volumetric, 2 25 c.c.
Pipettes, volumetric, 2 50 c.c.
Cylinders, measuring, 2 10 c.c.
Cylinders, measuring, 2 50 c.c.
Cylinders, measuring, 2 100 c.c.
Cylinders, measuring, 2 500 c.c.
Six T. K. dropping bottles, capacity 60 c.c.
Two gross microscopic slides.
Two-ounce coverslips, square 24 m.m.
Two well slides.
Two Buntzen burners (or equivalent, depending on gas supply).
Two iron tripods, three inches in diameter.
Four pieces wire gauze with asbestos, four inches square.
One centrifuge.
One hemacytometer.
One hemoglobinometer, Sahli.
One hemoglobinometer, Tallquist.
Two Esbach albuminometers.

Two urinometers with cylinders.
One microscope, B. & L., B.B.H., or equivalent.
Two casseroles, capacity 150 c.c.
Two forceps, dissecting, with fine points.
Two forceps, dissecting, medium heavy, straight
points, 115 m.m. long.
Two forceps, coverslip.
Four pencils for writing on glass (Blaisdell).
One colorimeter (Dunning).
One platinum loop.

This includes equipment only: supplies are not included.
—*Exchange.*

THE HOSPITAL PROBLEM IN RELATION TO MODERN MEDICINE*

DR. WILLARD C. STONER,

DIRECTOR OF MEDICINE, SAINT LUKE'S HOSPITAL, CLEVELAND,
OHIO.

The advances in scientific medicine and the rational application of the same have been phenomenal in the last twenty years. These advances have been of a nature that demands hospitalization very largely for the complete realization in medical practice. The old ideas of medical practice are being supplanted by the new. It is obvious that, under most circumstances, home conditions will not permit of improvised hospital facilities. It is impossible to bring hospital facilities to the home, so that it has become necessary to hospitalize more and more in order that we apply in diagnosis and therapy that which modern medicine affords. The well-trained surgeon no longer performs surgical operations in the home. The well-trained internist no longer attempts to diagnose obscure conditions in the home, much less manage them. The well-trained obstetrician no longer cares for the expectant mother in the home, which too often may be at the expense of both the mother and child. The public is being educated and appreciates the importance of hospital care.

*A paper read before the National Methodist Hospital and Home Association, Chicago, Illinois, February, 1922.

THE HOSPITAL A WORKSHOP.

The hospital no longer stands in disrepute as a place to go to as a last resort which generally ended in death. The hospital is being recognized as a workshop where there are facilities that represent the last word in scientific medicine and workers who represent the best in training and skill that modern medicine affords. The public is coming to realize that a hospital is a community problem, that it shall have community support and shall serve everyone, the poor, the rich, and the great middle class on whom a great hardship has come by reason of the tremendous cost of medicine if it is not afforded them by an institution at a cost which shall not make it prohibitive. The public is coming to realize that hospital practice by the medical profession shall not be abused, that the hospital shall not exist for a select few physicians of a community, but shall be accessible to all well-trained medical men.

It is obviously unfair to the young man who has thoroughly trained himself in modern medicine and satisfactorily met all the prescribed standards of qualifications to be turned loose in a community to try to practise that type of medicine which he has been trained to practise, without hospital facilities. It must ever be true that a certain percentage of illnesses do not require hospital care; this is especially true of the acute illnesses where the diagnosis is obvious and definite and where the course of the disease is likewise definite. Under such circumstances, good care can well be improvised at home and the well-trained physician who does home work suffers no handicap other than that of time in carrying into the home that necessary medical attention.

We had it well demonstrated in the army service in large numbers that a large percentage of acute illnesses require no particular medical attention other than good care, encouragement of elimination, and a proper diet. Nature is a good doctor and has more specifics for the cure of disease than is generally credited.

We must come to look on a hospital as a complete workshop, that is not a place to hospitalize bed-ridden patients alone, for diagnosis and treatment, but as a workshop for diagnosis wherein to advise treatment in the ambulatory case such as is being done in our free clinics and part-pay clinics.

The same principle in diagnosis must be applied to all material. It is a well-recognized fact that present-day medicine is organized to care for the destitute and the very well-to-do, but the great middle-class is unable to buy modern medicine. Fortunately the numbers whose conditions demand this type of medicine are in the minority so that society suffers only in a limited way.

CO-OPERATIVE CLINICS.

The development of co-operative schemes of work, that is the co-operative clinics such as are being developed all over the country, demonstrates the advantages of this complete workshop where the obscure acute, sub-acute or chronically ill may go for diagnosis and treatment. Obviously this affords the advantage of complete findings in an individual case with a single fee which is supposed not to be prohibitive to the individual. Unfortunately these private schemes of work represent a commercial basis as most medical men are not philanthropic to the extent of rendering service for which they do not have a regular return. These co-operative clinics have their advantages and disadvantages. The outstanding advantage is the completeness of work without a prohibitive fee and the outstanding disadvantage is the lack of personal interest in the patient and the failure properly to evaluate findings. Obviously these clinics do a certain amount of unnecessary work in order that necessary work be not overlooked. The complexity of modern medicine demands this sort of practice, hence the co-operative clinic is here to stay; but it can never represent the whole of medical practice and, if it did, it would be detrimental, robbing a large percentage of medical men of individual initiative and resolving medicine into medicine methods.

If we accept that the hospital represents a complete workshop for the hospitalizing of cases, and there is great advantage in having such a workshop in order that we apply modern scientific medicine, then we must accept that the hospital shall furnish the other portion of the workshop, namely, the diagnostic clinic where means are afforded for a proper diagnosis of all diseases such as our free clinics represent. Why shall we not look to the hospital as the complete workshop

where all cases difficult of diagnosis shall go and be investigated at a cost prohibitive to no one, where all worthy practitioners of medicine may take their cases for diagnosis and then have advantages of suggestions as to proper therapy? Life and health should not be made prohibitive to any one, and medical practice should see to it that it be within the reach of every one in so far as scientific medicine affords. Many of the co-operative clinics compete with the whole profession, that is, they not only take cases for diagnosis, but also for treatment. This will tend to lower the standard of medical practice, as it will take from the worthy man in general practice his best clientage and not afford him hospital facilities.

Hospital practice is a great incentive to do good work. Standardization of hospital practice such as is being done by the American College of Surgeons is tending to elevate the standard of medicine generally. Fads, quackery and sectarianism will thrive less when the people generally are educated as to the value and limitations of modern medicine. The facts of modern medicine rationally applied will bring a proper respect for medicine, greatly alleviate human suffering, prevent disease and eliminate a great waste. The hospital must ever be the important means of making these facts accessible to the public.

NEED OF RURAL HOSPITALS.

The establishment of hospital facilities in the rural communities must be the rational solution of medical practice in these districts. The investment in the modern training in medicine is too great to make rural practice inviting to-day. Better conditions must be the solution. Good roads and our present means of transportation make the establishment of hospitals in the larger towns in rural communities practical. It will be less and less necessary for the acutely ill to be taken to the larger centres for diagnosis and treatment, which is often at the expense of the well-being of the patient.

The hospital must have a larger responsibility in the education of nurses who shall enter the fields of preventive medicine and public-health nursing. The hospital must emphasize more and more the importance of regular complete exam-

inations for the purpose of detecting the development of diseases that are insidious in onset. It must afford health clinics where the facts of medicine may be obtainable to every one. The story of disease would be quite a different one if diagnosis were made early always, and the proper therapy applied. The hospital must furnish the same workshop that the industrial world furnishes for the man-made machine, *e.g.*, the automobile motor. May we not think it reasonable to have inspections of the human machine in the same way? Modern medicine affords a means of diagnosing early. Disease diagnosed late generally represents either indifference on the part of the patient or a failure to properly apply the means that modern medicine affords, or perhaps both.

ORGANIZATION AND CORRELATION OF HOSPITAL SERVICE.

The satisfactory work of a hospital depends in part upon proper organization and correlation of the administrative, professional, nursing and social service functions of the hospital. It is well to have the professional service divided into the two great groups, *viz.*, medicine and surgery, with a director of each division. Under each division shall be classed the departments which by nature of work shall be determined either medical or surgical. It is well to have the director of medicine serve as head of the department of general medicine and the director of surgery as head of the department of general surgery. Each department under the medical or surgical division shall have a departmental chief who shall be directly responsible to the division director.

A medical council is made up as follows, *viz.*, superintendent of hospital, the director of medicine, the director of surgery, and a fourth member who shall be selected by the department heads, not including general medicine and general surgery, and shall serve for a period of one year. The medical council shall determine or initiate all matters of policy and standards of professional efficiency which shall be subject to the approval of the board of trustees. Upon invitation a representative of the professional services chosen by the medical council shall meet with the executive committee of the board of trustees.

The medical council meets weekly to consider all matters that have to do with the professional services of the hospital. The professional services of the out-patient department are organized in the same manner as professional services in the hospital. All visitants to the hospital have professional responsibility in the out-patient department. The department chiefs are directly responsible for the type of service rendered in the out-patient department. The superintendent of the hospital directs the administrative function of the out-patient department, which work is under the supervision of the director of the out-patient department.

The medical personnel of the out-patient department has access to the open ward cases and certain responsibility in the routine care under the direction of the department chief.

The out-patient department is open from 8.30 a.m. to 10 a.m., which gives the medical staff the advantage of completing their hospital work early in the day and does not necessitate their return to the hospital for an afternoon clinic. The out-patient department is patterned after a semi-private clinic and has facilities and equipment to make it a complete workshop such as modern medicine affords. The work in the medical and children's clinic is done by appointment which enhances the appreciation and co-operation of the patient. Time is thereby controlled, and loose, hurried-up, incomplete work is not done. All medical men, either staff or non-staff, must limit their hospital practice to one specialty in order to encourage the highest standard of hospital practice.

The social service department determines the social status of every patient applying to the out-patient department for professional service. The medical clinic department determines all diagnoses and classifies accordingly. The social service department keeps a follow-up system and, where failure to report at a stated time, a card or letter is mailed or, if necessary, a home call is made. A daily record of all ward entries is furnished the social service department, likewise a report of all discharges.

Reports of the work of the out-patient department, the house staff, and nursing service are made to the medical council weekly.

The medical staff meets monthly, or oftener, for the purpose of holding clinics and discussing matters of professional efficiency. Then the personnel of a modern hospital is organized into a great working force having in mind a single purpose, the rendering of skilled professional care, and emphasizes at all times the humanitarian side of scientific medicine.

Hospital treatment of the sick must ever represent skilled, sympathetic care which must never be at the expense of the patient's rights, arbitrarily taken from him because of undue authority on the part of the nurse or physician.

In conclusion, let me emphasize the great need of amplifying hospital facilities everywhere. That the hospital must be made a complete workshop accessible to all reputed physicians; that it must represent all that modern medicine affords in preventive medicine, research medicine, diagnostic medicine, curative medicine and social service; that it must be an institution of learning where nurses, physicians and social workers shall be trained in every phase of scientific medicine; that it must render service to every one at a cost that shall never be prohibitive; that the institution shall realize, as the medical profession realizes, according to responsibility and service rendered.—*Exchange.*

A METHOD FOR INCREASING EFFICIENCY WITHIN THE HOSPITAL

FRANKLIN R. NUZUM, M.D.,

*Medical Director, Santa Barbara Cottage Hospital,
Santa Barbara, Calif.*

Outside the hospital many agencies have developed whose aim is the uplift of medicine. But within the hospital there is no special agency or department whose chief duty is the elevation of the plane of medicine practised in that institution. If hospitals are to keep pace with the demand for better medicine, they must assume responsibility for the patient's progress. They must also assume responsibility for the four functions long attributed to them, namely: (1) the care of

the sick; (2) the education of future personnel; (3) research and medical science, and (4) serving the community as the centre of all health promotion activities.¹

Up to the present, comparatively few hospitals have made special efforts toward assuming these duties or becoming more than mere nursing institutions. One way in which this plan may be accomplished is here suggested.

There should be established within the hospital an agency whose chief duty is the prosecution of a never-ending campaign for better medicine in that institution. For this work the full-time service of a medical man should be procured, who, for want of a better name, may be called the "medical director." His first duty is the organization of laboratories. With these well equipped and manned, he then calls the attention of the visiting staff to the benefit that may accrue to the patient from the proper use of the laboratory facilities.

He effects the proper staff organization with the various sub-groups. He brings before them regularly the various medical and surgical problems that arise in the institution. He keeps in touch with the especially ill patients in the house, and with those in whose cases it is difficult to arrive at a diagnosis. He discusses the situation with the attending man, offers suggestions if possible, and advises further consultation, if indicated. The accomplishment of a smoothly functioning staff, with team play developed to a high degree, with its members aiding one another by suggestion and example to obtain from the laboratories and other equipment all the help possible in diagnosis and treatment, would stand out in sharp contrast to the manner in which physicians practise in most hospitals at the present time. The co-operation and spirit of helpfulness which it is possible to establish among members of a staff, especially when one man, such as a medical director, makes it his business to effect such harmony, results in creation of a postgraduate school in that institution.

Such a staff would eliminate the competitive element of present day medicine within the hospital.² In its place would be substituted the newer ideals of specialization, team play, and thorough intensive study of individual patients. These ideals are spreading rapidly throughout the country because better service is rendered the public. Such a hospital will

gain the confidence of the community and serve as an educational institution in that community—the thing most needed to combat the propaganda of state medicine, social insurance and the numerous quacks.

Another of the difficult problems of the day is that of effecting a plan whereby the newer procedures in the practise of medicine may be taken up more quickly by the practitioner of medicine. Even after an excellent procedure has been worked out in the experimental laboratory, and its application to clinical medicine has been definitely established, there is a lapse of a long period of time, usually of years, before it is adopted by the profession at large. Here is another opportunity afforded the medical director. He has established a library in the hospital and, through a journal club or some similar agency, the literature in a large group of journals is abstracted and discussed at regular intervals by the staff. He suggests that certain of the newer procedures be tried. He provides the equipment, and trains a technician if necessary. The method, thus tested, will soon demonstrate its worth. If it is of no value, it can easily be dropped. If it is of value, that group will profit by its use over a period of several years before they would otherwise have become familiar with it.

The advancement of research and medical science, the third field of endeavor of the medical hospital, has a value so well recognized that it calls for no discussion here. Since most hospitals have not recognized their opportunity in the field of research, they have made no provision for such persons on their staff. This, again, would come under the scope of the medical director.

Two difficulties come to mind in putting into operation this plan of medical director. The first is in selecting the proper man for the position. The success of the undertaking is intimately associated with the character of the man who shall act in such a position. Naturally, he must be well-trained, broad-minded, sympathetic and co-operative, if he is desirous of making the plan a success. A narrow-minded, selfish man, be he ever so well qualified personally, would make a failure of the undertaking.

The aim of the medical director is one of help and of services to help the hospital provide adequate equipment for all diagnosis and treatment; to help the individual physician in making use of the equipment for the good of the patient; to help the staff by promoting a spirit of team work among them. In such a position a man has an unlimited field.

The second difficulty attendant on adding a new agent to the hospital staff is the financial question. Two means of financing such a department merit attention. In one instance the fees collected from the laboratory, after the laboratory was reorganized and the attention of the staff had been called to the importance of routine laboratory tests, very nearly bore the expense of the new undertaking. A second method lies in interesting some philanthropic individual who will personally meet the added expense.

CONCLUSION.

Hospitals should represent the best in medicine and surgery. Outside the hospital, specialization, group practice and health centres³ are becoming popular because they are an advance in the demand for better medical practice. In order to be progressive, hospitals must meet new conditions as they arise. The time is at hand when a patient entering a hospital should have an assurance that he will receive careful study and adequate treatment. This cannot be done under the regimen of a nursing hospital. It means that hospitals must become medical institutions and that there must be in their organization the same elements of team play and co-operation among the various specialists and men on the staff that obtain in group medicine outside the hospital.—*The Journal of the American Medical Association*.

REFERENCE NOTES:

¹Warner, A. R.: Medical Care is Measure of Hospital's Real Service, *Med. Hosp.*, 16: 325 (April), 1921.

²Mayo, W. J.: The Medical Profession and the Public, *J.A.M.A.*, 76: 921 (April 2), 1921.

³Billings Frank: The Future of Private Medical Practice, *J.A.M.A.*, 76: 349 (Feb. 5), 1921.

GOVERNMENT GRANTS TO HOSPITALS

The decision to make the distribution of the Government grant to the hospitals conditional upon the raising of an equal amount of new money has met with almost universal disapprobation among those interested in hospitals. The Ministry of Health, however, has taken a very firm stand in the matter, and the cogency of the arguments in the letter which Sir Alfred Mond contributed to *The Times* a month ago cannot be gainsaid.

It is common ground that the country as a whole demands, and has the greatest right to expect, the strictest economy in all Government expenditure. When, however, the cutting down process begins, each interest which is attacked is at great pains to show that it at least should be spared. Nothing is gained by viewing such a question from purely partial and, therefore, biased premises, although in the case of hospitals there may be some justification for this attitude. Undeniably, during the war they rendered great services to the State, for which they were very inadequately remunerated, and which had a disastrous effect upon their financial position. At the same time their work for the general public had perforce to be curtailed, with the result that long waiting lists were compiled, and the leeway has still to be made up.

When the Cave Committee recommended a grant of £1,000,000 from the Treasury to meet the deficiency, the hospitals were buoyed up with the hope that they were in a fair way of being placed on their feet again. Their hopes, however, were speedily dashed to the ground when the prospective grant was cut in half. Later, the "pound for pound" bombshell was dropped in their camp, and those hospitals who have exhausted all their ingenuity in the past two years in exploiting new sources of income are wondering where the new money is to come from to enable them to claim what in other circumstances would be a fair share of the grant. Unquestionably, some hospitals on this basis of distribution will fare worse than others, and through no fault of their own.

Nevertheless, we have much sympathy with the Minister of Health in the action which he has felt compelled to take. It is quite clear that he is a firm believer in, and supporter of, the voluntary principle, and we believe that the feature

which is most closely identified with that principle in the minds of the general public is derivation of income of the hospitals purely from voluntary sources. Already that conception has been modified by the substitution of the word "mainly" for "purely." To go beyond that would be to obliterate this feature entirely, and we should have to fall back upon the other definition of a "voluntary" hospital, namely, that it is one which is under voluntary and independent management—a meaning which carries with it the suggestion that it is immaterial, so far at any rate as the voluntary principle is concerned, whence the income is derived or in what manner it is expended. Sir Alfred Mond says, and we think reasonably, that if he were bent on the abolition of the voluntary system, no surer way could be devised than for the Treasury to make unconditional grants. No one will deny that, if at all possible, it is to the interest of the hospitals that they should work out their own financial salvation. Efforts to secure new income must not be relaxed, but the temptation to do so when there is a certainty of a State subsidy surely cannot be overlooked by any practical man of affairs.

The new money may be either "raised or in sight." Already there is a considerable amount earmarked for the hospitals by many of the approved societies. This is expected to amount to over £100,000 a year, and is a source of income which may conceivably prove much more valuable as time goes on, and although it may have an effect upon patients' contributions, at least it substitutes a certainty for an uncertainty. Much may reasonably be hoped for from the local hospital committees in their attempts to systematize and co-ordinate methods for the collection of money. Sources of income which have proved so prolific in some areas are waiting to be tapped in other areas, and there are few districts but have their distinctive Pactolean stream only waiting for the enterprising bather. The news that that great philanthropist, Lord Mount Stephen, who during his lifetime gave half a million pounds for the same purpose, has bequeathed the residue of his fortune to the King Edward's Hospital Fund for London comes as a reminder, if reminder were needed, at the end of a trying year for the hospitals, that the country still possesses generous benefactors who believe in the future of the voluntary hospitals.

Even a successful economy campaign in the Governmental departments must in the long run benefit the hospitals, for, undoubtedly, the hand of many a potential benefactor is stayed because of the ruinous taxation.

All this makes us feel that although much is being said about the "tragedy of the hospitals," the turning of the tide is at hand, and the new year opens with a gleam of hope that the *dénouement* of the tragedy will be such a relief from financial worries as will enable the voluntary hospitals to forge ahead to fulfil their high destiny.—*English Exchange*.

TORONTO GENERAL HOSPITAL

The Toronto General Hospital closed the year 1922 with a deficit of \$68,702, exceeding the deficit of the previous year by some \$4,000. As compared with 1921 figures the 1922 receipts and expenditures both showed decreases. Last year's operating expenses were \$960,479; those of 1921, \$1,001,342. Revenue for 1922 totalled \$911,777; that of 1921, \$937,251.

These figures were handed out at the conclusion of the annual meeting of the Hospital Board of Trustees, held behind closed doors in the main building of the hospital.

After some discussion the board decided to make representations to the Special University Committee in connection with the controversy that recently raged between the University Medical Faculty and the General Hospital.

Although the members approached were not disposed to discuss the question, it is understood that the board is definitely opposed to any considerable alteration in the methods and personnel of the present administration of the General Hospital, and that the memorandum to the Special Committee of the Legislature will take that attitude.

This is borne out by the board's adoption of Superintendent C. J. Decker's report, in which he said: "In my mind this institution is rendering a service to its patients and to humanity in the teaching of medical students which has never been excelled in its history. It is doubtful whether we will find anywhere more efficient service than is now being given through our professional organizations in the hospital."

Executive officials of the board were re-elected, as follows: chairman, C. S. Blackwell; vice-chairman, Dr. D. Bruce Macdonald, and secretary, C. J. Decker.

Statistics presented by the superintendent indicated comparatively small changes in the volume of the hospital's work during 1922, as compared with 1921. Patients admitted totalled 10,393; in 1921 the total was 10,938. Number of out-patients treated: 1922, 61,108; 1921, 59,963. Total collective days' stay of in-patients: 1922, 221,683; 1921, 225,466. The in-patients remained in hospital for an average of 18.2 days. Operations numbered 6,745.

Of the in-patients 53.6 per cent. were Canadian, 21.6 per cent. English, the balance being made up of thirty different nationalities. Jewish patients were 4.5 per cent. of the total.

CONJOINT CONVENTION OF THE WESTERN CANADA, THE MANITOBA, AND THE WESTERN CANADA CATHOLIC HOSPITAL ASSOCIATION

A joint meeting of the Western Canada Hospital Association, the Manitoba Hospital Association and the Western Canada Catholic Hospital Association was held in Winnipeg, November 13th, 14th, and 15th, and will go down in history as being one of the most successful and inspiring hospital meetings ever held. There were many outstanding features of the meeting which are well worthy of mention, but here are just a few:

First—The wonderful and inspiring address of Dr. A. D. Stewart, President of the Manitoba Hospital Association, full of outstanding features throughout.

Second—The clear-cut and complete exposition of the Saskatchewan Hospital System by Dr. F. A. Middleton, assistant to Dr. M. M. Seymour, Commissioner of Public Health for Saskatchewan.

Third—The splendid representative attendance, embracing a large number of members of governing boards, doctors, hospital officials, nurses and others. Every session was filled to the theatre's capacity.

Fourth—A sound, practical programme, with few long papers or addresses, but all sessions taken up mostly with round-table conferences for the discussion of the common every-day practical problems. In the discussion almost everybody present took part.

Fifth—The practical and instructive exhibit, with many demonstrations of technique and procedure, which accompanied many of the subjects discussed.

Sixth—The announcement of Dr. Fred Bell, Secretary of the Medical Faculty, Manitoba Medical College, that a closer study would be made of the smaller hospitals in an endeavor to extend internship to the various institutions throughout Western Canada, providing that satisfactory arrangements could be made with the hospitals. In this work the approved list of hospitals, as issued by the American College of Surgeons, will be used as a guide.

Seventh—The resolution passed by the joint conference endorsing hospital standardization, which reads as follows:—

Whereas the American College of Surgeons, composed of over six thousand of the leading surgeons of Canada and the United States, is international in character and in functions;

And whereas this organization has initiated, developed and carried out an invaluable constructive programme for the betterment of our hospitals;

And whereas this programme has, even in so short a space of time, effected an enormous improvement in the professional services of our hospitals;

Be it resolved, That we, the Western Canada Hospital Association, assembled here in convention, representing the four western provinces of Canada, namely, Manitoba, Saskatchewan, Alberta and British Columbia, again reiterate our very hearty endorsement of this great work and service, unparalleled in the history of hospitals, and leading to such an improved efficiency; and we hope that such work may be continued and carried on actively in the future as in the past, till every hospital in Canada, regardless of size or type, meets the requirements;

And, further, be it resolved. That this Association, as well as each of its component units, pledge themselves to render all the assistance possible to those charged with the duty of carrying on such an important and excellent work.—*Carried unanimously.*

There were many other outstanding features which should be mentioned herein, but a fuller account will appear later. The convention demonstrated the great inspiration and stimulation that is aroused by the various provinces getting together in the discussion of problems which are common to all their hospitals.

ISOLATED DISEASE OF THE SCAPHOID

Four new cases of isolated disease of the scaphoid are reported by Barclay W. Moffat, New York (*Journal A.M.A.*, Jan. 13, 1923.) The clinical picture is that of a child of from four to eight years, giving a history of trauma varying from a turned ankle to a crushing injury beneath an automobile. The symptoms, which are occasionally entirely absent, are a slight limp and discomfort at the sight of the scaphoid, increasing often to actual pain at night. The signs, which are also inconstant, are enlargement of the scaphoid, as shown by palpation, and tenderness. Abscess formation never occurs. The treatment is rest or immobilization in plaster for from three to ten weeks. A mechanism of the disease which would seem to account for all the facts is the following: Through trauma, or possibly some unknown factor, the bone is enlarged. This is demonstrable by palpation and would also account for the abduction of the fore part of the foot found in these cases. In weight-bearing, this enlarged bone, as the keystone of the arch, is subjected to anteroposterior pressure, resulting in a flattening and spreading out laterally of the soft, newly formed osseous portion. The biconcave appearance presented would thus be accounted for. As the constituents of the bone—cartilage and osseous material—are still present, conversion of cartilage into bone continues as in the normal bone. The subsidence of the symptoms corresponds in time roughly to the re-establishment of bony architecture throughout all of the portion made visible by the roentgen ray.

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SUCTION IN THE TREATMENT OF LARYNGEAL DIPHTHERIA

In an effort to avoid intubation, Harry R. Litchfield and Reginald P. Hardman, New York (*Journal A.M.A.*, Feb. 24, 1923), in the past permitted patients to remain dyspneic for hours, sometimes to the point of exhaustion, struggling for air, hoping that they might ultimately expel the membrane, or that the antitoxin might check its rapid formation. At present they employ suction promptly, and as frequently as indicated. The patient is wrapped in a mummy bandage as for intubation, and through a Jackson laryngoscope the membrane and mucus are aspirated by means of a sixteen to eighteen French silk or metal catheter, which is connected to an aspirating bottle, and in turn connected to an ordinary electric suction pump, capable of producing from five to ten inches of vacuum. From May until the last part of December, 1922, 106 patients with laryngeal diphtheria were admitted to the croup service at Willard Parker Hospital. There were twenty-one mild cases which required no treatment. Twelve patients received applicator treatment. Intubation was performed in eighteen cases. Nine patients received suction and intubation. There were forty-six cases in which suction was used exclusively. The total number of deaths was fourteen, a mortality of thirteen + per cent. Of the eighteen patients subjected to intubation, eight died with terminal bronchopneumonia. Three of these were moribund on admission; eight have been discharged cured, and two are still in the hospital, and cannot go out without their tubes for any

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considerable length of time. Two patients who underwent tracheotomy died. Of the nine patients treated by suction and intubation, two died, and the rest recovered. Both patients had bronchopneumonia on admission. The remaining two deaths occurred in the series in which suction was used exclusively. Both these patients had toxic tracheobronchial diphtheria. They were ill about four days before admission; one had, in addition, a pharyngeal involvement. Suction is especially advocated for cases in which there is a low membrane, which cannot be reached by either intubation, tube or tracheotomy.

HYGIENIC PAPER GOODS

The attention of the readers of THE HOSPITAL WORLD is called to the advertisement, now running in the journals of Stone & Forsyth Co., 67 Kingston St., Boston, Mass. This firm are perhaps the largest manufacturers in America of Hygienic Paper Goods and Specialties for Hospitals and Sanatoria. Their goods are too well-known to require more than a mention. Among the lines they manufacture are *Sputum cup refills and holders, pocket sputum cups, wood specimen boxes, wood tongue depressors, wood applicators, paper napkins, paper towels, paper drinking cups.*

Any institution that has not up to the present given this firm an order will do so to their own advantage, the goods being of the very best quality in every respect.

VERY HIGH BLOOD PRESSURE AND CONGENITAL HEART DISEASE

Louis Faugeres Bishop, New York (*Journal A.M.A.*, Feb. 24, 1923), speaks for a variation in type of structure of the circulatory system involving a right predominance, with which, later in life, a higher blood pressure usually appears, without any definite disease. It is not a common type. These patients present, in different degrees: (1) a very high blood pressure with none of the usual causes, such as defective kidneys or hardening of the arteries; (2) an anomalous finding in the orthodiagram and electrocardiogram, and (3) a remarkably slight inconvenience from the very high blood pressure, e.g., 230. The importance of recognizing the condition lies in the fact that the patient must not be treated as an invalid, but must be allowed to lead a normal life, as far as her strength goes. The benefit of this treatment was evident in an improvement as soon as a rational plan of living was instigated and the fear of heart failure was put aside.



DR. SENIOR: "So you've been appointed Consulting Surgeon to the Vigo Iron Mills, eh?"

DR. JUNIOR: "Thanks to your kind recommendation, yes——"

DR. SENIOR: "I'm very glad——"

DR. JUNIOR: "I am also glad that the Mills are so near that I can run in and sit under the influence of my former teacher's experience and wisdom at times."

DR. SENIOR: "This little Brochure just arrived, should interest you—in fact it should interest every physician who is called on to treat industrial injuries. It contains photographs of first aid departments of many of the largest industrial plants in the United States and all of them carry a supply of Antiphlogistine."

DR. JUNIOR: "Oh! I've already ordered a case of Antiphlogistine, to have it handy."

DR. SENIOR: "I see you have made the right start—and don't be afraid to use Antiphlogistine freely—especially in those severe burns which happen so often in rolling mills. The non-toxic antiseptics—boric acid, oil eucalyptus, oil gaultheria—make Antiphlogistine absolutely safe, in abrasions of the integument, and the well-established fact that its osmotic action conveys these antiseptics into the circulation, insures against systemic infection from uncleanly surroundings. Send to The Denver Chemical Mfg. Co., 20 Grand St., N. Y. C., for their 'Industrial Plant' booklet."

VAGINAL DOUCHE.

While Vaginal douches, as a therapeutic measure, cannot be considered as a cure for all pelvic affections they nevertheless have a wide field of application.

They can be divided into three groups although in practice these various types are combined with one.

1. Hot douches.
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CARCINOMA OF THE STOMACH: REPORT OF CASE, AND EXAMINATION EIGHTEEN YEARS AFTER OPERATION

John Dudley Dunham, Columbus, Ohio (*Journal A.M.A.*, Feb. 24, 1923), cites the case of a man who when fifty-two years of age was told he had a cancer of the stomach. He was operated on. The stomach was the seat of a tumor extending from the region of the pylorus along the lesser curvature to its middle. The growth partially closed the pylorus, involving the peritoneum on the anterior gastric wall. Subtotal gastrectomy was performed after the Mayo method, one inch of the duodenum being removed, and a posterior gastro-enterostomy with Robson bobbin was done. The pathologic diagnosis, gross microscopic was: carcinoma of the encephaloid type. This diagnosis was confirmed by Dr. Francis Carter Wood of New York. Following operation, the patient had a stormy convalescence, but slowly and steadily improved. In December, 1922, the patient, aged seventy-one, appeared to be healthy, and his digestion was perfect. He ate six times daily, indulging in all varieties of food. The only abnormality noted was a feeling of hunger. This case is reported as a plea for more frequent gastrectomy for cancer of the stomach.



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THE HEART IN PERNICIOUS ANEMIA

The postmortem findings in eleven cases of pernicious anemia are analyzed by William D. Reid, Boston (*Journal A.M.A.*, Feb. 24, 1923). The most constant finding was "fatty degeneration" of the myocardium. Thrombi were not found. Electrocardiograms were taken from twenty patients. No abnormalities of diagnostic significance were found. The Q-R-S-T interval was of normal duration. This demonstrates that the increased output of the heart, described by Fahr and Ronzone, is not accomplished by a lengthening of the ventricular systole. There is ample reason for keeping at complete rest a patient who is ill with a severe attack of pernicious anemia. The fat noted in "fatty degeneration" is brought to the heart by the blood, in accordance with a normal physiologic process; and evidence is wanting that the efficiency of the myocardium is impaired thereby. Untoward reactions that sometimes follow transfusions of blood in cases of pernicious anemia are not primarily cardiac in origin.

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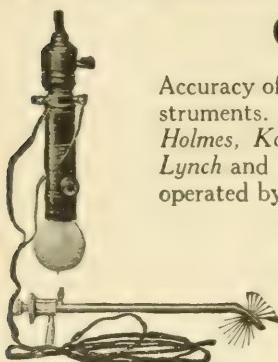
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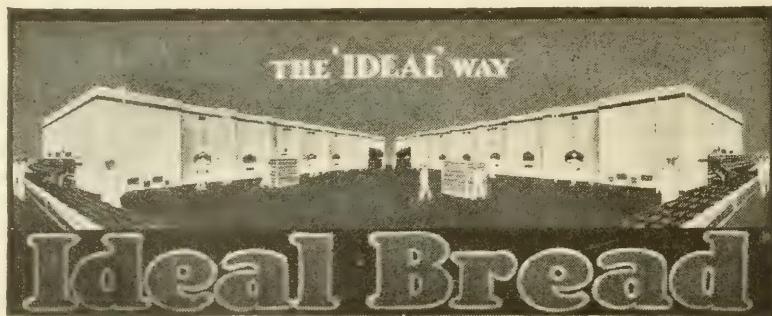
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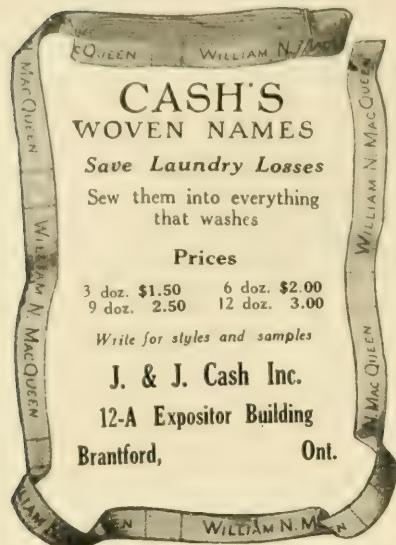
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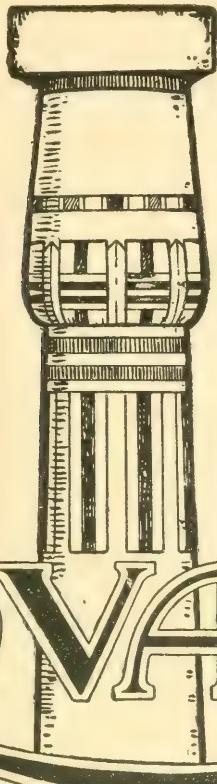
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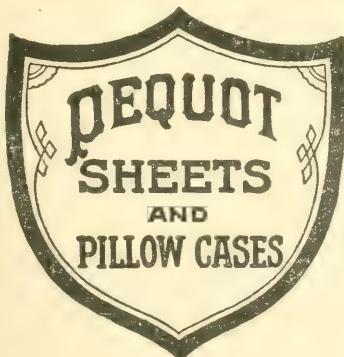
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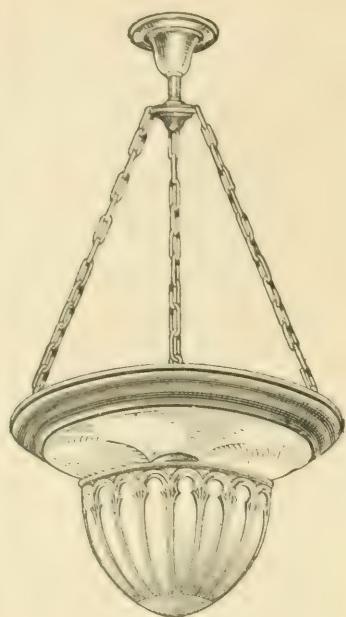
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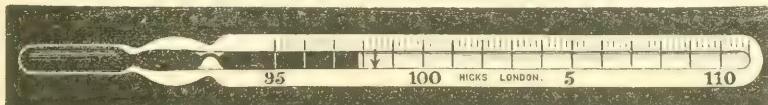
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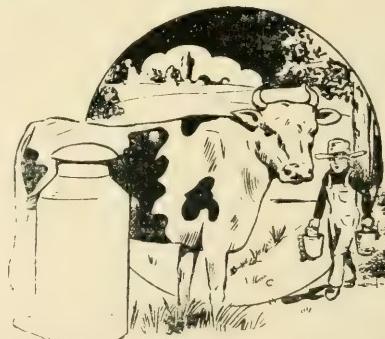
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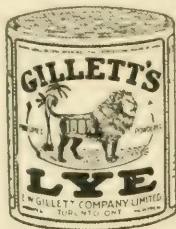
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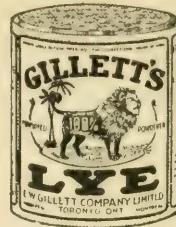


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TORONTO, CANADA

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Vol. XXIII

TORONTO, MAY, 1923

No. 5

Editorial

Hospital Standardization in New Brunswick

The standardization of the St. John hospitals necessitated the revision of the conditions under which physicians practised in them. A committee was appointed and formulated the regulations.

These stipulated that there should be no secret division of fees; that autopsies must be held wherever possible and records of same filed with the case records; also that the pathological, bacteriological and X-ray findings must be filed with the case records. Physical examinations are to be made and recorded by the house officer, but in all cases the attending physician and surgeon shall be held responsible for the records of their patients. A tentative diagnosis is to be made within forty-eight hours of the patient's admission. In surgical cases the surgeon's pre-operative diagnosis must be posted before the operation. The post-operative diagnosis must be recorded immediately after the

operation; and all tissues removed are to be sent to the pathological laboratory for report. Follow-up records shall be kept by a record clerk. Throat smears and other examinations as to infections shall be made of all children admitted. Vaginal smears are to be made in suspicious cases. The chiefs of service must instruct the house officers at the bedside upon the salient points of diagnosis and upon the management of cases. The superintendent must keep a record of the house officers as to their personal conduct and professional ability.

A committee of five is to be appointed annually by the commissioners on the recommendation of the staff, to see that proper methods of efficiency are maintained throughout the hospital.

Monthly meetings of the medical staff are to be held. Failure to attend three meetings renders the delinquent liable to dismissal. At these meetings a review is made of the clinical experiences of the group in the various departments. A summary of deaths, infections and complications is to be prepared and presented for discussion.

The staff shall consist of all registered practitioners in St. John City and County who subscribe to the regulations and have obtained the privilege of treating patients in the hospital.

The staff officers are chairman, vice-chairman and secretary. The chairman and secretary are members of the hospital medical board. A record of attendance at staff meetings is kept. The officers

are elected by nomination and ballot at the regular December meeting and assume office at the first meeting in January.

The order of business is (a) Presentation of interesting pathological material collected during the previous month, with remarks by the pathologist. (b) Reading the casualty report and discussion of same by the physicians and surgeons responsible. (c) Report of cases of special interest.

The Voluntary System

A conference representing 112 metropolitan (London) hospitals was recently held to discover the best means of improving the financial condition of the voluntary hospitals. The chairman favored the preservation of the voluntary principle. The crisis through which they were passing threatened the very life of the voluntary system, and with it the most valuable institutions incorporated in that system. The Government had given half a million pounds and the public an equal amount, but in spite of this help, many London hospitals were facing serious deficiencies. Parliament should be invoked for a further grant. First and foremost an organization should be developed which would ensure that every member of the community contributed a share for the upkeep of the hospitals. The Manchester scheme, whereby all workers in the city made contributions, was worthy of emulation.

Hospitals should be exempted from rates and duties on legacies, and individuals who gave considerable and regular donations should be relieved, to the extent of those donations, from income-tax.

Dr. Gordon Dill recommended the inauguration of a policy which would relieve the hospitals from the anxieties attendant upon their haphazard and hand-to-mouth mode of life. The necessitous did not constitute 25 per cent. of the patients at any hospital in these days, and yet hospital services were an ultimate necessity to the remaining 75 per cent. and could not be obtained elsewhere. Hospital patients were invited to make voluntary contributions, but the average of these was at most 12s. a week. The balance had to come from charitable funds.

How could it be made possible for the people to whom the hospitals were a necessity, but who were not themselves necessitous, to pay the out-of-pocket cost to the hospital of the services they received? The only possible solution was that while in health they should individually become regular annual subscribers of a definite amount which would suffice collectively to pay for those of them who were admitted to hospital in the course of the year.

The above suggestion corresponds somewhat with the idea of Mr. Richard Bradley, a philanthropist of Boston, who recommends a form of insurance to meet the need.

Safety First in Anesthesia

Hoag, of Pueblo, Colorado, makes a contribution to the anesthetic supplement of the *American Journal of Surgery* in which he inquires of his brother anesthetists, *Are you taking part in the nation-wide safety-first movement in anesthesia originated by the National Research Society?* If not, he says, you are missing a valuable opportunity of placing your specialty upon its proper plane. Hoag points out that this movement is based primarily on Miller's conception of determining the surgical risk of the patient by means of the blood pressure rules of Morts and McKesson. Once the surgical risk is known are you in a position, he inquires, to examine the patient before the operation, and, have you the privilege of selecting the anesthetic and dictating preliminary medication? If not, he maintains, you are in an awkward position with regard to practising a specialty, and the sooner you can convince your surgical associates that your knowledge in these respects exceeds theirs and that your judgment is more to be relied upon the sooner you will be recognized as a consultant. *To achieve this rank (the italics are his) it devolves upon you to become proficient in making and evaluating every possible method of differential diagnosis, and it is in this respect that the anesthetist must be an all-round physician.*

You must keep yourself and the operator (he continues) informed as to the patient's condition throughout the entire operative period by continu-

ous attention to all the signs and symptoms of anesthesia. The charting of signs and symptoms as recommended by McKesson, Guedel and others is of material assistance, but even more important is the five-minute blood pressure readings to determine if the patient is still in the zone of safety, or has entered one of the three degrees of circulatory depression. All patients, too, should be watched post-operatively as to their blood pressure reactions.

Training School Needs

Sister Bartholomew, writing in *Hospital Progress*, states that a training school should have a general class room with desks and chairs, plenty of blackboard space, anatomical and obstetrical charts, a stereopticon with numerous anatomy, histology and pathology slides illustrating sections of tissue. There should also be a manikin, a skeleton and first-aid charts.

It should also contain a dietetic kitchen with proper tables, cupboards, hot plates, bake oven, dietetic and meat charts in a spacious room, as well as a complete dietetic laboratory. In this laboratory the student should be taught the testing of cow's and mother's milk. There should also be scientific laboratories for teaching chemistry, pathology and bacteriology; each student having one month's practical work in urinalysis, blood counting, and other essential procedures.

There should also be available a pharmacy in which student nurses may receive training in the preparation of medicines.

There should also be a library, open at all times.

A demonstration room is also needed, equipped with a chase doll and bed, and with all other facilities for teaching nurses. Here the tray system is prepared and used for demonstrations of every kind, such as:

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Toronto, Canada

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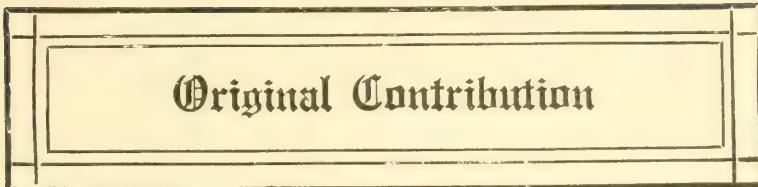
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Original Contribution

AMERICAN COLLEGE OF SURGEONS

HOSPITAL STANDARDIZATION.

A high ideal of hospital service, a vision of community responsibility, a method by which this responsibility can be met efficiently day by day—this is Hospital Standardization. The following pages contain a report for 1922 of the progress of this movement—that of giving to the public the best service known to the science of medicine. It stands as a tribute to the idealism and the service of the combined medical and hospital professions.

For the past decade, American hospitals have been passing through a state of change. The development of modern surgery and medicine, the advancement in diagnostic procedure, the forward strikes of pathology and roentgenology, made severe and confusing demands upon hospitals. In addition, medical men, hospital executives, and public health officials began to conceive of the hospital in a new light; that of an institution which centralizes in itself every department of modern medicine; which makes itself not only the clearing house for treatment, but also the headquarters of community health activities. Some such conception came to the minds of medical men and hospital executives, who were striving to give their communities the best in modern medicine. And this widening of responsibility was altogether natural. Hospitals, founded on a basis of service, had as their dominant motive the inherent desire to improve this service and to extend it to the entire community. The standardization programme of the American College of Surgeons became the medium through which these ideals of the hospitals found adequate expression. It proposed a programme of hospital service which voiced the needs and the ideals of hospitals them-

selves. Small wonder, then, that such a programme has been adopted so rapidly. The soil had been prepared, the minimum standard was the seed, and better hospital service was the fruit thereof.

Hospitals ten years ago, as to-day, varied in size and scope from the clinical teaching organization of the large cities to the tiny hospital often owned and operated by a pioneer surgeon in an outlying town. Could every hospital, irrespective of size and financial condition offer reliable, honest service to its patients? Were there any fundamentals for hospitals applicable to every type of institution found in the American continent?

The determination of these fundamentals and their practical application clearly constituted the first step toward improvement. By correspondence and by actual visits to hospitals, the leading medical and hospital minds of America attacked this problem.

These men were not idle theorists—rather they were successful medical men of broad vision and hospital executives who were coping with actual conditions day by day. After careful consideration they elaborated four fundamentals without which no institution is worthy of the name of hospital. Later, these fundamentals became known as the minimum standard for hospital service, and under the leadership of the American College of Surgeons this standard has been adopted by the majority of hospitals of the United States and Canada.

The success of this movement is one of the most fascinating stories in the annals of American medicine.

Soon after its organization, the American College of Surgeons felt the urgent need of improving hospital records, as applicants for admission to the College were required to submit as a part of their examination one hundred case records of major operations. These records were so incomplete and fragmentary in many instances that the College became thoroughly convinced of the necessity for a wide-spread campaign to improve them. This was the initial germ causing the hospital standardization movement; as it developed, other factors in hospital betterment presented themselves, such as the need for more adequate laboratory service and more efficient

staff organization. Accordingly, hospital superintendents, members of boards of trustees, and physicians of national repute were consulted in the endeavor to determine the best plan for instituting the necessary improvements.

Although, in general, the hospitals of the United States and Canada were very commendable institutions, no far-seeing individual could deny the existence of certain weaknesses which needed correction. It was decided in 1918, therefore, to send out questionnaires to all the general hospitals in order to obtain complete information concerning the existing status of the following fundamentals: the type of staff organization, the extent to which hospital results were analyzed, the abolition of the practice of fee-division, the status of the case records, and the extent of the laboratory service. Replies to these questionnaires strengthened the growing conviction of the College that a personal survey of hospitals was imperative.

Next, a standard was needed upon which to base the survey, and leading authorities in the medical and hospital world were consulted further with this end in view. It was decided that the standard should be confined to the fundamentals which would insure the best hospital service; that it should be broad enough to be applicable to all general hospitals, and still detailed enough to avoid misinterpretation of the principles involved.

The hospital staff quite naturally was selected as the first essential to be considered in the standard. As a man often may be judged by the company he keeps, so also may a hospital be judged by the character and ability of its staff members. Restriction of staff membership to the ethical and competent, therefore, was admittedly necessary in order for a hospital to live up to its community trust. The necessity for some definite type of staff organization was mentioned because organization leads to efficiency, and lack of efficiency is inexcusable where human lives are concerned. The practice of fee-division was denounced as absolutely incompatible with honest hospital and medical care; physicians buying and selling patients should have no place on a reputable hospital staff. Hospitals were urged to adopt a constitution and by-laws with specific reference to professional care, the keeping of records, and the

attendance at staff meetings, because most hospital constitutions included no mention of such important essentials. Above all, the fundamental importance of regular staff conferences to analyze hospital results was especially emphasized. Failure to hold such meetings, besides being the chief reason for staff disharmony, was responsible for the lack of realizing the full benefit from the hospital's vast clinical experience.

The basic importance, also, of complete case records needed strong emphasis. Realizing that the majority of physicians kept relatively meagre office records, the hospital was considered the logical repository for the medical records of the community. It was a regrettable fact that many hospitals could furnish little evidence as to the amount of study made of each patient before treatment. From an economic standpoint alone, the value of the procedures carried on in the hospital was too great to permit of their being lost by failure of being recorded.

The rapid strides made by clinical and X-ray laboratories called for a more complete use of these important departments. There was a general deficiency in the quantity and variety of laboratory tests performed in hospitals. The operating room and pathological laboratory needed a closer correlation; each patient was entitled to more routine laboratory service.

With these considerations in view, the minimum standard was evolved in 1919. Whether it has stood the test of time is best answered by the fact that it has not been modified since its inception.

1. That physicians and surgeons privileged to practise in the hospital be organized as a definite group or staff. Such organization has nothing to do with the question as to whether the hospital is "open" or "closed," nor need it affect the various existing types of staff organization. The word *staff* is here defined as the group of doctors who practise in the hospital, inclusive of all groups such as the "regular staff," the "visiting staff," and the "associate staff."

2. That membership upon the staff be restricted to physicians and surgeons who are (*a*) competent in their respective fields and (*b*) worthy in character and in matters of professional ethics; that in this latter connection the practice of the division of fees, under any guise whatever, be prohibited.

3. That the staff initiate and, with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work of the hospital; that these rules, regulations, and policies specifically provide:

(a) That staff meetings be held at least once each month. (In large hospitals the departments may choose to meet separately.)

(b) That the staff review and analyze at regular intervals the clinical experience of the staff in the various departments of the hospital, such as medicine, surgery, and obstetrics; the clinical records of patients, free and pay, to be the basis for such review and analysis.

4. That accurate and complete case records be written for all patients and filed in an accessible manner in the hospital; a complete case record being one, except in an emergency, which includes the personal history; the physical examination, with clinical, pathological, and X-ray findings when indicated; the working diagnosis; the treatment, medical and surgical; the medical progress; the condition on discharge with final diagnosis; and, in case of death, the autopsy findings when available.

5. That clinical laboratory facilities be available for the study, diagnosis, and treatment of patients, these facilities to include at least chemical, bacteriological, serological, histological, radiographic, and fluoroscopic service in charge of trained technicians.

Designed as a universal, as well as a minimum standard, it must be restricted to the basic principles underlying the best hospital service. There are many variable factors such as size, type, and location, which influence a hospital's procedure in carrying out certain policies. To meet these varying conditions, the standard omits any detailed description of how its principles should be enacted. It leaves this for each hospital to decide in accordance with local needs. Where there are several equally efficient means to an end, dogmatism in insisting upon one method hampers hospital initiative. This limitation to fundamentals, and avoidance of unnecessary detail, gives the standard sufficient elasticity to meet varying situations. The viewpoint of the College looks toward certain end-results, rather than upon specific methods to be used in securing such results.

The College recognizes the importance of many features not mentioned in its standard; these lack, however, sufficient uniformity in various hospitals, states, and provinces to warrant an equitable basis for comparison and rating. The published report of approved hospitals must be just. And the more complicated the standard, the greater will be the likelihood of error in selecting the list of institutions meeting it. It is believed, furthermore, that in the careful observance of all the principles of this standard, the various unmentioned features will be cared for automatically.

The first consideration in the minimum standard, and rightly so, is the hospital staff. It is unfortunately true that organization in hospital effort has not advanced to a degree comparable with its development in other technical lines. Surely there is no excuse for the human repair shop—the hospital—to fall behind in organization, always all important in promoting the highest efficiency. Responsibility for the various activities of the hospital must be centred in certain committees or individuals. The programme for the staff meetings, the case records, the laboratory service, the nursing care, and the interne service, are but a few of the important activities, the responsibility for which should be centralized.

As the strength of a chain varies with its individual links, so the status of a hospital rises and falls with the strength or weakness of its component staff members. Restriction of hospital privileges to the ethical and competent, therefore, is essential.

The goal of the organized staff, and indeed the aim of the standardization programme, is the analysis of the hospital's results. As expressed by Mr. John G. Bowman, "the staff meeting is the pivot upon which the success or failure of hospital standardization turns." It is the medium, through which this entire campaign finds expression. Without it, a hospital's efforts, to a large degree, fail.

The form of this analysis varies according to the type of organization. Whether combined staff meetings or departmental conferences are held is immaterial, so long as all the special activities of the hospital are represented.

The staff conference, perhaps more than any other factor, has improved the tone of hospital service during the past few years. It is the feeling of the College that these meetings should be devoted largely to a discussion of the so-called casualties, including deaths, infections, complications, and unimproved cases. Occasional hospitals still adhere to the belief that such meetings violate the confidential relationship existing between the physician and his patient. One naturally assumes that all the physicians present in a given staff meeting are ethical and competent; if not, they have no place on the hospital staff. Granting this assumption, all that occurs in this meeting is held in strict confidence by each physician present. The names of the patients are not divulged during the confidence. The discussion is impersonal, being an analysis of a clinical event, and the relationship of that event to the hospital. Even if the patient's name be known to a few it should have no bearing subsequent to the meeting.

Experiences encountered in hospital practice probably exceed in value those occurring in any other line of endeavor, and their true value is not approached, unless they are portrayed in the staff conference. The confidential relationship between the physician and his patient is not violated; it is elevated to the much broader conception of a confidence reposed in a frank, co-operative group of fellow practitioners—the hospital staff.

One of the great advances in modern medicine has been in the direction of laboratory aid in diagnosis. Indeed, this constitutes one of the greatest distinctions between the practice of medicine to-day and that of our forefathers. Hospitals owe their patients the benefit of this advance in medical science. The laboratory in no sense, however, should be considered as a short-cut to diagnosis, supplanting the careful taking of a history and a painstaking physical examination. Combined with the latter, however, it furnishes an invaluable means of assistance, often making clear an otherwise obscure diagnosis.

The necessity, then, for making careful arrangements for adequate laboratory service, needs no argument. As a minimum, hospitals should have facilities for the examination of urine, blood, exudates, bacteriological slides, and for the growth of cultures. It may be impractical, however, for some hospitals to have equipment for the more technical examinations, such as serological and histological tests. Arrangements

must be made with a reliable laboratory for accurate and prompt service for these more detailed examinations. Where material has to be sent outside of the hospital, there is an unfortunate tendency to reduce the number of specimens sent. As a result, laboratory service suffers. Unfortunately, the number of qualified pathologists and serologists is too small to supply each hospital individually, and as inaccurate laboratory reports are worse than none, the only recourse at the present time is the practice of sending certain specimens to adjacent laboratories.

To help obviate this difficulty it is customary to employ technicians. Adequate provision for their supervision, however, is often neglected. If a pathologist is not available, some staff member versed in laboratory work should be selected for this purpose.

Even in hospitals with complete laboratory facilities, one frequently finds laboratory service markedly deficient, due to the insufficient quantity of tests performed, especially for private patients. This is due largely to two causes: first, the system of charging an individual fee for each test performed; and second, to the apathy of many staff members toward the laboratory. It cannot be too strongly emphasized that almost without exception, hospitals which charge individual fees for their laboratory tests, perform a relatively small number of tests per patient. Under such conditions, naturally, the hospital cannot assume a definite routine of laboratory service, as an immediate objection to the cost would be raised. The only solution apparent at the present time, is the adoption of a flat-rate fee. This allows the hospital, and rightly, to assume the responsibility of having each patient receive adequate laboratory aid. The uniform success of this plan has been proved in so many instances, that it can be accepted as an established fact.

The installation of X-ray equipment has proceeded so rapidly that the supply of roentgenologists can scarcely meet the demand. Although technicians may become proficient in many phases of the work, the problem of adequate roentgenological interpretation is more difficult to meet. Each X-ray department should have a qualified roentgenologist in charge,

if only in a part-time, supervisory capacity. Patients, in general, do not receive uniformly competent service if interpretations are relegated to individual physicians.

The College makes no specific recommendations concerning the number of routine laboratory examinations to be employed by hospitals. A routine urinalysis, of course, is performed in the majority of hospitals. Many perform a routine hemoglobin determination and leucocyte count also—a practice to be strongly recommended. Some hospitals have a routine Wassermann test in certain wards or services. Fortunately, the practice of having a routine examination of every tissue removed in the operating room is becoming quite prevalent. This is a factor of paramount importance. Every specimen from the operating room should be sent to the laboratory automatically; this should be as rigid a part of the operating room technique as the sterilization of instruments. Every specimen should be examined by the pathologist, who submits at least a gross report of his examination and has a histological examination made whenever possible. Data of tremendous scientific value are becoming available due to the practice of sectioning practically all specimens from the operating room. Furthermore, this practice gives the hospital an insight into its operating room service that can be obtained in no other way.

The absolute and fundamental importance of case records is a commonly acknowledged fact and needs no argument here. A careful study of the history of a patient's illness and a painstaking physical examination are procedures of such great importance that their value must be preserved. Failure to record these data, constitutes a tremendous economic loss and waste, to say nothing of the future bearing on the welfare and lives of the patients. How then, can the possession of a complete record system be facilitated? Its accomplishment requires the mutual co-operation of the hospital and its staff members.

The duties of the hospital in this connection consist, first of all, in supplying adequate personnel to secure the records. In the absence of internes, record clerks are essential. Even the small hospital is entitled to a full-time historian, although it is quite common for these historians to devote part of their

time to other activities of the hospital. It is because the responsibilities and many duties of the historian are so little realized that so small an amount of time is allotted to her. With careful training she can record many of the essential points of the personal history; the physical examination records should be taken by dictation from the physicians. This relieves the staff members of considerable time and labor. In addition, the historian should keep close watch of the current records to see that they are recorded promptly; she notes whether the history, physical examination record, and working diagnosis are recorded before operations; she keeps in close touch with the progress notes, which explain the course of the patient's illness; and she checks over the records carefully to see that they are complete before filing.

An efficient record committee is a necessary adjunct to the historian's work. In this committee is vested the responsibility for the interpretation of the records. Other of its functions are a persuasive stimulation of the physicians to improve their records; a periodical review of the charts of the discharged patients; and the selection of the records to be analyzed at the staff conference.

Many hospitals fail to provide adequate space for the record department. For this purpose a room large enough to contain the records of many years should be set aside, adjacent to the hospital office. All plans for new hospitals should bear this important feature in mind. This department should contain standard filing cabinets and card indices for names and diseases; for each record must be immediately accessible. The cost of this equipment is slight in proportion to the value received; perhaps no expenditure is more warranted.

After supplying the equipment and personnel needed for a modern record department, the hospital can expect the physicians to insure the accuracy of the records. Although much of the time and labor in securing records can be borne by the hospital, the responsibility for the records themselves lies with the physicians. Unless constantly checked and supervised by the staff members, the records will contain many inaccuracies. In many small hospitals the physicians write all the records personally. Whether recorded by internes, historians, or dictated to clerks, however, the physicians should scrutinize the

records closely and signify their approval in writing before the charts are filed. Physicians too often take no interest in the records of their patients written by internes; as a result, the records are frequently inaccurate and brief. Staff supervision is a great stimulus to internes, the character of whose work reflects the interest displayed in it by the staff members.

Personal study in over sixteen hundred hospitals during the past four years has shown a progressive improvement in the records. Certain prevalent shortcomings, however, are worthy of special emphasis. Extreme brevity is a common fault, coupled with a tendency to dismiss important regions of the body from consideration, by too promiscuous use of the words "normal," or "negative." A tendency to a stereotyped form of history and physical examination record is encountered frequently. Such charts have little individuality or clinical value and result from two causes: failure to record the data until shortly before or after the patient's discharge; and lack of supervision of the records by the hospital staff.

The importance of having the working diagnosis recorded early is insufficiently realized. This, in itself, will correct many existing difficulties in connection with other phases of the records. Operation records are almost universally weak in describing the exploratory findings and operative technique. The solution for this seems to be the dictation of these data during or immediately following each operation.

Case records are not to be filed and forgotten; if so, most of their potential value is lost. Inseparably linked with the staff conference, the records form the only basis for a true analysis of a hospital's results. The depth of this analysis varies in direct proportion with the detail and completeness of records. Many treasures are buried in hospital record rooms for lack of discovery and analysis. Unquestionably, one of the greatest future advances in hospitals will be in the direction of statistical, analytical research based on complete records.

The hospital surveys of the College are *personal* surveys. Experience has shown that a study of hospital conditions through correspondence and questionnaires leads to many inaccuracies. The College surveys are conducted through a trained corps of hospital visitors, all of whom are graduates in medicine. The number of visitors employed in any year has never

exceeded ten. Since the uniformity of a survey varies in inverse proportion with the number of men employed by using relatively few visitors, all similarly trained, the College obtains strictly uniform reports. As an additional safeguard, each visitor covers a large number of states and provinces in order that he may obtain a general, rather than a local viewpoint of hospital conditions. This uniformity in the reports is an absolute essential to a just rating of hospitals. Upon such detailed personal surveys, the College is dependent for an accurate estimate of each hospital's status relative to the minimum standard.

The purpose of the visitors is to explain the minimum standard, to interpret its application to each hospital, and to offer constructive criticism and helpful suggestions to remedy any existing shortcomings. This campaign is one of suggestion only; there is no element of coercion entailed. It succeeds through the sanction and approval of the hospitals themselves.

Other organizations interested in hospital betterment have played a prominent rôle in advancing hospital standardization. The programme of the College has been enhanced greatly by the endorsement of such organizations as the American Hospital Association, the American Conference on Hospital Service, the Canadian Medical Association, the Catholic Hospital Association, the Conference Board of Hospitals and Homes of the Methodist Church, the Medical and Surgical Section of the American Railway Association, the Methodist Hospital Association, the Protestant Hospital Association, and numerous state, provincial, and local organizations.

Internes and nurses are using the approved list of the College as a guide in the selection of institutions in which to pursue their training. The public is making increasing use of it as a means of determining which institutions offer safe and competent hospital care. Benevolent foundations employ it in deciding upon hospitals which are worthy of financial aid. The American Railway Association has recommended that all railroad employees, wherever possible, be treated in hospitals meeting the minimum standard. The United States Government, in its selection of hospitals for the treatment of its disabled veterans, utilizes the information furnished through the surveys and approved lists of the College.

Four annual surveys of the general hospitals in the United States and Canada have been made. Of the institutions having one hundred or more beds, eighty-nine were found to meet the standard in 1918; in 1919, 198 fulfilled the requirements; in 1920, 407 or fifty-seven per cent. met the standard; in 1921 the number of approved hospitals grew to 579 or seventy-six per cent.; and this year 677 or eighty-three per cent. of the 812 hundred-bed general hospitals are on the approved list.

Of the 811 general hospitals having a capacity of between fifty and one hundred beds, 335 or 41 per cent. are approved, an excellent showing in view of the fact that previous lists published by the College have not included these smaller institutions.

Grouping together the 1623 general hospitals having fifty or more beds, there are 1,012 or sixty-two per cent. meeting the requirements of the standard.

Although the College has been surveying the smaller hospitals since 1920, it was deemed advisable to withhold their publication on the approved list until sufficient time had elapsed to give them an opportunity to familiarize themselves thoroughly with the standardization programme.

The smaller hospitals are under greater difficulties than the larger institutions. Many are forced to be practically self-supporting; the physicians are more prone to develop personal rivalries which retard staff organization; it is difficult for them to obtain internes; and sufficient laboratory service is often a serious problem. In spite of these difficulties, however, the small hospitals have welcomed the minimum standard with the same spirit manifested by the large institutions. Indeed, it is in these small hospitals where the greatest change in hospital service has been manifested. It requires patience to establish a complete case record system; to organize a harmoniously functioning staff; and to arrange for adequate laboratory service. These small institutions are to be especially commended, therefore, on the excellent showing which they have made.

In the United States and Canada there are 811 general hospitals having between fifty and one hundred beds. Of these, 335 or 41 per cent. are on the approved list. This exceeds the percentage of hundred-bed hospitals which met with approval at the time of the first survey.

The surveys of the College have demonstrated that the hospitals of this continent are receptive to any means of improving their service to the public. As the sphere of hospitals has widened, so have their responsibilities increased. Sensing these ever deepening responsibilities and obligations, hospitals looked forward to a means of satisfying their broadened conception and ideals of community service. The minimum standard and the standardization programme of the College furnished a concrete method by which these aspirations could be reached. The future will see the further elaboration by hospitals of the principles of the minimum standard and a fuller realization of the spirit embodied therein.

LIST OF APPROVED HOSPITALS.

ALBERTA

100 or more beds

- General Hospital, Calgary
- General Hospital, Edmonton
- Holy Cross Hospital, Calgary
- Medicine Hat Hospital, Medicine Hat
- Misericordia Hospital, Edmonton
- Royal Alexandra Hospital, Edmonton

50 to 100 beds

- Galt Hospital, Lethbridge
- Lamont Public Hospital, Lamont

BRITISH COLUMBIA

100 or more beds

- Provincial Royal Jubilee Hospital, Victoria
- Royal Columbian Hospital, New Westminster
- Royal Inland Hospital, Kamloops
- St. Joseph's Hospital, Victoria.
- St. Paul's Hospital, Vancouver
- Vancouver General Hospital, Vancouver

50 to 100 beds

- Vernon Jubilee Hospital, Vernon

MANITOBA

100 or more beds

- Brandon General Hospital, Brandon

- Children's Hospital, Winnipeg
- Misericordia Hospital, Winnipeg
- St. Boniface Hospital, St. Boniface
- Winnipeg General Hospital, Winnipeg

50 to 100 beds

- Victoria Hospital, Winnipeg

NEW BRUNSWICK

100 or more beds

- General Public Hospital, St John

50 to 100 beds

- Chipman Memorial Hospital, St. Stephen
- Hotel Dieu, Campbellton
- Hotel Dieu, Chatham
- Miramichi Hospital, Newcastle
- Moncton Hospital, Moncton
- St. John's Infirmary, St. John
- Victoria Public Hospital, Fredericton

NOVA SCOTIA

100 or more beds

- St. Joseph's Hospital, Glace Bay
- Salvation Army Maternity Hospital, Halifax
- Victoria General Hospital, Halifax

	50 to 100 beds	PRINCE EDWARD ISLAND
Aberdeen Hospital, New Glasgow		
Children's Hospital, Halifax		
General Hospital, Glace Bay		
Highland View Hospital, Amherst		
St. Martha's Hospital, Antigonish		
	ONTARIO	
	100 or more beds	
Carleton County Protestant General Hospital, Ottawa		
General Hospital, Kingston		
General Hospital, Toronto		
Grace Hospital, Toronto		
Hamilton City Hospital, Hamilton		
Hotel Dieu, Kingston		
McKellar General Hospital, Ft. William		
Ottawa General Hospital, Ottawa		
St. Joseph's Hospital, Hamilton		
St. Joseph's Hospital, London		
St. Joseph's Hospital, Port Arthur		
St. Luke's Hospital, Ottawa		
St. Michael's Hospital, Toronto		
Sick Children's Hospital, Toronto		
Victoria Hospital, London		
Western Hospital, Toronto		
	50 to 100 beds	
General Hospital, Brockville		
General Hospital, Sault Ste. Marie		
Niagara Falls General Hospital, Niagara Falls		
Nicholls Hospital, Peterborough		
St. Francis Hospital, Smith's Falls		
St. Joseph's Hospital, Peterborough		
St. Vincent de Paul Hospital, Brockville		
Smith's Falls Public Hospital, Smith's Falls		
Welland County Hospital, Welland		
Wellesley Hospital, Toronto		
Women's College Hospital, Toronto		
	50 to 100 beds	
Charlottetown Hospital, Charlottetown		
Prince Edward Island Hospital, Charlottetown		
	QUEBEC	
	100 or more beds	
Children's Memorial Hospital, Montreal		
General de St. Vincent Hospital, Sherbrooke		
Hotel Dieu, Montreal		
Jeffery Hale's Hospital, Quebec		
Montreal General Hospital, Montreal		
Notre Dame Hospital, Montreal		
Royal Victoria Hospital, Montreal		
Sainte Justine Pour Les Enfants, Montreal		
Western Hospital, Montreal		
	50 to 100 beds	
Montreal Maternity Hospital, Montreal		
Sherbrooke Hospital, Sherbrooke		
	SASKATCHEWAN	
	100 or more beds	
Grey Nuns Hospital, Regina		
Regina General Hospital, Regina		
St. Paul's Hospital, Saskatoon		
Saskatoon City Hospital, Saskatoon		
	50 to 100 beds	
Holy Family Hospital, Prince Albert		
Notre Dame Hospital, North Battleford		
Prince Albert Municipal Hospital (Victoria Hospital), Prince Albert		
Providence Hospital, Moose Jaw		

FOOD SERVICE IN HOSPITALS

MAUDE A. PERRY, SUPERVISING DIETITIAN, MONTREAL
GENERAL HOSPITAL.

Many complaints concerning food in all hospitals could be avoided if more attention were given to the service of the meals. When one realizes the difficulty of pleasing sick people, robbed by illness of a normal desire for food, it is natural to expect that even good, well-cooked food, improperly served, may fail to appeal to their capricious appetites.

The problem of food service in any hospital depends upon the equipment in the kitchen and on the ward, upon the distance to be traversed between these two, and upon the method by which the food is conveyed from one to the other. To make good foods attractive, it is absolutely necessary to serve hot foods hot and cold foods cold. It is easier to serve the cold foods than the hot ones in most cases. The food served in public wards must of necessity be plain, but it may be well cooked and properly served.

Several plans of food service are being successfully used in different hospitals to-day. Some of these have been adopted from necessity, where economy is the main thing to be considered, some from choice of some hospital official, or perhaps architect. Perhaps the oldest method is the service of food from containers sent from kitchen to ward in hot water boxes. Unless the boxes can be placed upon stoves and unless the meals can be served in courses, it is difficult to give to every patient in a large ward good hot food. As this service must be from the ward kitchens, it takes a great deal of time and labor on the part of the nurse to get out the meals satisfactorily. Nevertheless, it can be done if the food is served on previously heated plates conveyed to the patients as soon as served. It cannot be done well if delivery to patients is not accomplished until a carrier of ten or twelve trays have been served.

In some institutions the food is served in the main kitchen into insets which fit into the steam tables found in each ward kitchen or serving room. When this food is sent hot from the kitchen and placed immediately in the heated steam table awaiting it, one may find good service from this method. Unfortunately, sometimes the food is not served hot from the

kitchen or because of the distance which it must go, it does not arrive hot at the place of service. In such case, reheating of food properly, depends upon the one who has charge of the food after it arrives in the ward-serving pantry. If this person is more interested in the welfare of the patients than in "getting the meals out" this service may be very good. If, as sometimes happens, this care of the food is left to a maid who is careless about properly regulating the steam table, or if one attempts to serve too many trays at one time, patients will almost surely receive what should be hot foods, luke-warm or cold.

Probably the newest method of food service is by heated or insulated conveyors. These are sent either to ward kitchen or directly to the ward for meal service. Hospitals which have this method are quite enthusiastic in its praises. Certainly the conveyor which takes the food directly to the patient has solved a big hospital problem. These conveyors are either constructed on the fireless-cooker principle, which retains the heat for a long time or they are electrically heated. The carts having the separately built and insulated compartments are particularly valuable. Heat is retained longer, odors do not mix, and hot and cold foods may be sent by same wagon. As this conveyor may be wheeled around the ward it is never necessary to serve any patient any food which he will not eat. Surely this is much better than serving every plate for every patient, on similar diet orders, exactly the same, regardless of idiosyncrasies of different individuals.

This plan of service is economical for the institution as food waste may be reduced to a minimum. Any food remaining in the conveyor after all patients have been served, may be returned to the main kitchen in good condition. It does not dry out nor lose flavor in the fireless-cooker conveyor as it never needs to be reheated. For the same financial outlay, more variety in foods may be allowed and even public patients given some choice, especially of vegetables. Cold foods, as well as hot, may be nicely served to patients in a large ward, so a complete meal from soup to pudding may be served from one carrier in much less time than required by other methods and with much less confusion and labor.

In any plan of food service, the meals for sick people should be served by a nurse as she knows the patients and naturally has a greater interest in their welfare than anyone could have who is not familiar with them. She is vitally interested in anything which aids in their convalescence and she cannot help but see to what extent food alone contributes to this. Furthermore, this is a part of the nurse's training in most hospitals, just as truly as the administration of medicines or various forms of treatment to be given.

THE NURSE'S PRAYER

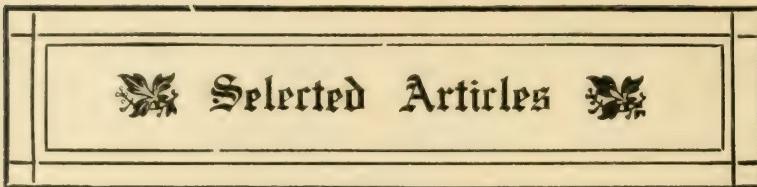
REV. OTTO BRAND, FIELD SECRETARY AND CHAPLAIN
OF THE METHODIST EPISCOPAL HOSPITAL,
BROOKLYN, N.Y.

O holy Father, to Thee my heart inclines, to Thee my fervent prayer ascends. Behold me, Lord, a nurse—just only one—amid this vast world's suffering. To the sweet task of pain's alleviation, the life-task of my choosing, I would this day re-dedicate myself. Supplement, I pray, with wisdom from above, my training of long years, that more and more, through Thy direction, it may become effectual in causing disease and misery to give place to health and happiness. So that the tide of death may be oft-times backward turned, and the day of mourning long postponed, help me in the art of nursing to excel, the holy art by angels taught.

O Christ, Thou Great Physician, instruct me also in those deeper things which to the sacred calling of our sisterhood belong. O Holy Spirit, Nurse of this dying world, minister through me to hearts that are sick as well as to bodies cruelly racked by pain. May my feet, O God, be ever swift to obey Thy slightest bidding. May these two prayer-clasped hands be found always willing to minister in tenderness to a fellow-creature's need. May the light of honest, human love so shine in these eyes of mine that they who suffer shall be convinced that one other heart, at least, can feel the sharpness of their pain. So control my spirit, Lord, that never from these praying lips shall fall one single harsh or bitter word, to cause an added twinge of pain in those committed to my care.

O Father, for all I ask, mine own unaided strength will not suffice. Thy gracious help I need, or else must surely fail. In my weakness aid Thou me, my Teacher and my God. By Thine own compassionate love inspired, Christlike would I live and serve to-day.

And when, dear Lord, my earthly course is run; when Thou shalt have no longer need of me; when other feet and other hands shall minister where mine no longer may: then, O God, unworthy though I be, grant, in mercy unto me, the sweet and happy rest of Heaven. Assist my earth-worn spirit to wing its homeward flight, until, in Heaven, Thy dwelling-place, its destined goal is reached. Thy voice it was that sent me forth, a nurse, upon my holy mission of relief. So again, dear Lord, at last recall Thou me, and cap me for that larger ministry of Heaven, reserved for those who serve Thee faithfully and well on earth. Amen.



Selected Articles

THE FINANCING OF HOSPITALS

To those of us in Canada who are so deeply interested in the financing of our general hospitals, the report just brought in by Lord Cave on hospital financing in the Old Country is exceedingly interesting, in so far as it is the first attempt on the part of the British authorities to rectify the serious financial condition of the English hospital situation of to-day. Hospital conditions in England have been so entirely different from hospital conditions in the New World that one can find very little in this report of Lord Cave that may be of practical assistance to those of us in Canada. The chief cause of the serious state of affairs in England is not difficult to find. Since their foundation extending back over hundreds of years, the custom in the large English hospitals has always been to treat every patient free of charge. No effort has at any time been made to investigate the patient's financial status in the community. At the same time it must be said, in all fairness, that the majority of the patients that have filled the wards of hospitals in England in the past could not have paid more than a tithe of the cost of their upkeep. It is probable, however, that a considerable percentage of the patients now occupying their public wards could afford to pay a small portion of the cost of their hospitalization, and one wonders why the English authorities have been so tardy in demanding from such, a definite contribution. While this would be regarded as a great departure from the traditions of the Old World, nevertheless, unless some radical movement along these lines is undertaken, it is doubtful if the Government will come forward and continue to bear the entire cost of the annual deficits.

For several years it has been the practice in Canadian hospitals to make a small charge for the public ward patient in cases in which upon investigation by the social worker such a charge seems warranted. This not only tends to instil into the patient a spirit of independence, as opposed to one of pauperism, but it becomes at the end of the year great assistance to the finances of the hospital. By way of example we may state that in looking over the records of one of our Canadian hospitals we note that in 1917 the revenue from the public wards of that institution was in the neighborhood of thirty thousand dollars. Little or no effort had been made at that time to collect, where possible, even a small sum from the patients. That hospital was slowly committing financial suicide. With the ever-increasing cost of maintenance it became apparent that some means must be taken whereby the revenue might be increased. An energetic movement was started and each patient's account was carefully scrutinized. The result of this was that in 1920 the revenue from the same public wards was over ninety thousand dollars. By such means the income of many hospitals may be increased, and it is reasonable to think that Governments will be induced to listen to the pleas of those institutions that are endeavoring to help themselves, and come forward with some plan whereby hospital finances may be placed on a sound basis. Many authorities, however, are of the opinion that the only relief which the future holds for the financial condition of our hospitals is a general per capita tax made on all residents in each city or Province, out of which tax, assistance shall be rendered to our hospitals on the basis of the quantity and quality of the medical attention given to the poor; while at the same time philanthropic citizens who desire to perpetuate their own name or that of some relative or revered friend will have the opportunity to give or bequeath funds sufficient for the erection of the buildings made necessary by the steady growth of our cities. While the serious financial conditions of the English hospitals are demanding the earnest consideration of all in England, Canadian institutions realize that steps must be taken in advance to prevent this misfortune occurring here. Unfortunately the character of assistance rendered by the Provincial and municipal governments has

in the past been very uncertain. It is our hope that the time is not far distant when under federal or Provincial guidance, financial assistance will be rendered to all accredited hospitals, for surely the supervision of the health of our citizens is quite as important as the upkeep of roads, canals, police and other departments that have become recognized as necessary to the safety and well-being of our country.—*Canadian Medical Association Journal.*

HOSPITAL PUBLICITY

The American Methodists work out their publicity campaign as follows:

Let us first list up some of the channels of publicity open to a local hospital or home, whether it be for the regular or general publicity or for campaign publicity. Among these are the following:

1. The newspaper.
2. The Church Press.
3. The institutional monthly paper.
4. Annual reports.
5. Booklets and leaflets.
6. Occasional bulletins.
7. Personal and circular letters.
8. Lantern-slide lectures.
9. Moving pictures.
10. Personal presentation.
11. Pulpit presentation.
12. Epworth League and Sunday school institutes.
13. Camp meetings.
14. Local Church Societies—Ladies' Aid Society, Epworth League, Brotherhood, etc.
15. Use of special days—Hospital Sunday, Mothers' Day, etc.
16. Preachers' meetings.
17. The Annual and District Conferences.
18. Area gatherings.
19. Medical and Hospital and Homes publications.

With this list must go your fields to cultivate:

1. The Bishop of the area.
2. The District superintendents and pastors of your territory.
3. The physicians of your territory.
4. Wealthy members of Methodist Episcopal churches.
5. The churches in your territory, including all their organizations.
6. Patients who have been served by the hospital, especially those of wealth.
7. Nurses trained by the hospital.
8. Families who have adopted children from church homes.
9. Friends and relatives of the old folks in Homes for the aged.
10. Wealthy people locally in the immediate community served by the institution.
11. The local community generally.

Then decide absolutely just what your publicity shall be for. The following suggests the scope:

1. To keep the church and public informed and to create background.
2. To secure workers.
3. To secure inmates or patients.
4. To develop personal interest.
5. To secure money.
6. To secure supplies.

Manifestly it is impossible to discuss all of these phases of publicity in the time available. But those phases which are discussed, point in many ways to the possibilities of those untouched.—*Selected.*

FEEDING SICK INFANTS

In the care of sick infants not only do those suffering from some form or other of digestive disturbances amount to more than one-half the number of cases where the services of the nurse will be required, but, inasmuch as an undisturbed metabolism is of paramount importance for the happy ending of any illness of babies, the nurse must be familiar with the

most common modifications of cows-milk, their purpose, action, and preparation. No less should she be acquainted with the composition of the widely used, and much advertised, proprietary baby foods. No less must she master the theory and practical carrying out of breast-feeding, which, in far too many cases, seems impossible or impracticable for the simple reason that the young mother, in her inexperience, does not know how to do it, and that the nurse is unable to show her. Furthermore, the nurse should have all the arguments why breast-feeding is best for babies on the tip of her tongue, so that she will be able to contradict all those more or less vague objections against it, brought forth by grandmothers and other members of the family, or even by meddling neighbors. Thus the nurse must know that the milk will sometimes not be present in abundance until as late as the sixth week after the birth of the child, and she must be convinced of the fact that only in very rare cases is the quality of the mother's milk at fault, but that it is mostly the quantity of the milk given to the infant which is to blame, as can readily be proven by careful weighing of the baby before and after nursing. In this connection, I would like to request the nurse to use her influence with prospective mothers, whenever she is consulted in time, against their wasting good money on spring-scales for this purpose as only balance scales weighing at least half ounces, but better still quarter ounces, are of any use.

The most important in the feeding of sick infants and children, and one which the nurse must always hold before her mind's eye, is this—that next to oxygen, water is the most important requirement for the organism. While everybody is aware of the fact that the human body can survive a very short time only when deprived of air, few seem to realize that desiccation of the body due to insufficient amounts of water, is also fatal within a relatively short time; the younger the individual, the shorter. During illness, the output of water, through respiration, perspiration, through the excreta and defecta, and in consequence of fever, is considerably increased and this must be replaced correspondingly. The young infant requires three ounces of liquid for each pound of body-weight, up to one quart in twenty-four hours, and in older children this amount of water is the least with which

they can carry on the most essential physiological functions of the body. The nurse must, therefore, be an adept in the administration of water, which may vary in every given case, be it by gavage, by the Murphy drip, by mouth, or rectum, by enema, or subcutaneously; and this amount of water must not only be administered, but actually retained.—*Selected.*

THE USE OF LIGHT IN HOSPITALS

A most interesting paper was read by Mr. John Darch at the discussion upon the use of light in hospitals, arranged by the Illuminating Engineering Society.

Speaking first of the hospital ward, Mr. Darch advocated a light that should be quiet and pleasing, best obtained by a system of general lighting combined with local lighting. The general lighting need not be great, anything from one-half to one-foot candle, well diffused and without glare. The light should be spread evenly over the ceilings and friezes. Each patient should be provided with his own local light, giving him three foot-candles upon his book. This may be set on a short, smooth bracket close to the wall so as not to be in view of the patient. It should not be in the centre of the bed-head as usual, but about fifteen inches to the patient's left so as to avoid heat on his head and gloss on his book.

Local lighting is also necessary on the sisters' and nurses' tables, and each should have one or more well-shaded table-lamps adjustable so as to give an average of four-foot candles. The decoration of the ward is an important factor in its illumination. Although ward and ceilings and walls are frequently to be found varnished, there should be no gloss above the dado. The ceilings and friezes should be white, the walls below are better of a quiet and restful color, darker or lighter according to window space and aspect. As regards the operating theatre, whatever arrangements are made, the highest possible degree of asepsis should be maintained, yet the fittings suspended over the tables are often thickly coated with dust. One should admit the greatest possible angular expanse of glass without admitting direct sunlight, and the glass should extend nearly the length of the room. The ideal light for operations should be made to approximate to that found quite away in the open under a clouded sky.

The illumination should not be less than five-and-twenty foot-candles, and the light should be so thoroughly diffused that it should be difficult to get the shadow of one's hand upon the work. No exposed light sources should exist within the field of vision. The color of the light should be as white as possible, and it must be uniform and steady. In special circumstances the surgeon can use an electric forehead light.

The author has seen nothing better for the purpose of illuminating the operating room than the white flame arcs we had before the war. He specially mentions the method more in favor abroad than here, viz., that of projected beams of light converging on the table from several points.—*Selected.*

SOME ADVANTAGES WHICH NURSES ENJOY

With calls for trained nurses coming from all sorts of new places every year; with new institutions being opened every week, with the great unworked fields in foreign lands calling for help—for the service that only trained nurses can render—it behooves every reader to help in recruiting the right type of woman for the schools of nursing to train.

There is no occupation or profession without its disadvantages, and nursing is no exception to this rule. But it has advantages of no mean order over a great many other occupations which now freely offer open doors for women to enter. First, it does not require anything very big in the way of finance and is thus opened to many young women who could not secure a professional or technical education if they had to be entirely responsible for every item of expense during training.

Second, nursing is pre-eminently a woman's occupation. Men do succeed in it, but the highest positions in the nursing world are not open to men, and the average nurse has little, if any, competition from male nurses. The field for male nurses is limited, while the demand for women nurses is constantly increasing and the field is practically unlimited.

Third. The well-trained nurse who is willing to serve and who can adapt herself to varying situations can always find work. Whether she goes east, west, north or south, she will encounter human need and the right sort of woman will find her services in demand.

Fourth. The training which a nurse receives is an excellent preparation for a great many other lines of work, so that if one tires of nursing, it is not difficult to take an excursion into the business world, nor to find an entrance to many kinds of social service.

Fifth. If she wishes to marry and establish a home of her own, her training is an excellent preparation for home-making and motherhood.

Sixth. The financial rewards are fairly good, and the average nurse who has been industrious in her early years, and sensible about the way she spent her income, should be able to have an income from her investments before many years.

These are only a few of the considerations which should be presented to the possible candidate who is facing the choice of a vocation.—*The Trained Nurse.*

REDUCING THE LOSS OF HOSPITAL LINEN

1. Have a careful system of marking linen. A blunt pen with indelible ink, pressed in with a hot iron, is the simplest plan, and is more durable than rubber-stamp markings, though these may also be used. Linen for the operating room, for the out-patient department, for nurses' rooms, for the private pavilion, should be marked with the symbol of the department.

2. Take an inventory of the linen supply at stated intervals, so that loss may be detected. This is not a tedious task if wisely managed. It can be done in an hour in the ordinary hospital if proper blanks are used for records. No linen should be changed or moved from one room to another while the count is going on. When new linen is added to the supply in circulation a list of the articles should be added to the inventory. Stringent rules against employees appropriating worn or old linen for use in cleaning should be enforced.

3. A central linen room is an economy. It definitely places responsibility for the giving out and checking of linen, and once the system is established, few institutions would care to do without it. A roomy basement room can be easily fitted

with the necessary shelves, cupboards, drawers, tables for sorting, etc. An extra room for sorting all soiled linen should be close by. The matron of the linen room is responsible for collecting and counting. The person in charge of the laundry must receipt and account for linen delivered to him, his receipt being returned to him when clean linen is returned.

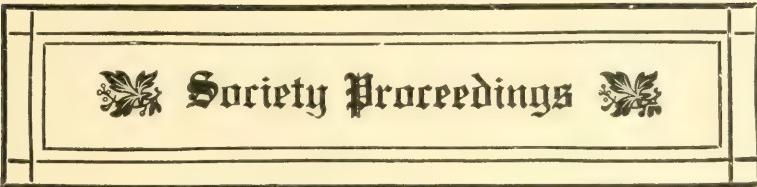
4. Linen to be discarded should be listed and checked off the inventory.

5. Linen is distributed to the different departments by an exchange of as much clean linen as there is soiled linen taken away. Additional linen should be issued only on requisition of the head of the department and should be received for.

The high cost of cotton goods of all kinds for the past few years has made strict economy a necessity and this is only possible when a careful system of accounting for linen is in use. If it is not possible to secure and pay a full-time seamstress for mending and making up new supplies, it is nearly always possible to secure volunteers from the Ladies' Aid Society of the Hospital to donate one day each week to assist the hospital in this way.—*The Trained Nurse.*

EGG AS A SOURCE OF VITAMIN B.

By extraction of egg yolk with water, Thomas B. Osborne and Lafayette B. Mendel, New Haven, Conn. (*Journal A. M. A.*, Feb. 3rd, 1923), secured a product comparatively rich in vitamin B, the daily dose required for a 100-gram rat being considerably less than that of the most potent dried yeast hitherto examined. The contents of the egg yolk in vitamin B is not large, a daily intake of at least 1.5 gm. of the fresh yolk being required when it furnishes the sole source of vitamin B to a 100-gram rat. The whole egg is accordingly not exceptionally rich in vitamin B, when contrasted with other foods already investigated. Judged by the comparative trials on rats, the average sized hen's egg is equivalent in vitamin B potency to about 150 c.c. of cow's milk, or a quart of milk and six or seven whole eggs of the average sort have an approximately equivalent vitamin B value.



Society Proceedings

THE NATIONAL HOSPITAL DAY COMMITTEE

E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, and vice-chairman of the National Hospital Day Committee, has been appointed chairman, succeeding Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn. Dr. Sexton, who was first chairman of the committee and who directed the observance of first and second National Hospital Day, remains as a member of the committee, although increasing responsibilities as president of the New England Hospital Association, and other activities, prevent his again serving as chairman.

The new chairman is widely known throughout the hospital field, having been active in national association hospital affairs for several years. He is a founder and the four-time president of the National Methodist Hospitals and Homes Association. At the 1922 convention of the American Hospital Association Mr. Gilmore conducted the section on building in a most efficient manner. Dr. Malcolm T. McEachern, general superintendent, Vancouver General Hospital, Vancouver, B.C., who is on a year's leave of absence to conduct a survey of Canada for the Victorian Order, succeeds Mr. Gilmore as vice-chairman. Dr. McEachern, who is president-elect of the American Hospital Association, continues as Canadian director for the movement.

Two new members have been appointed to the committee for 1923: C. J. Cummings, superintendent, Tacoma General Hospital, and Dr. Albert S. Hyman, superintendent, Mt. Sinai Hospital, Philadelphia, Pa., succeeding former members who are now out of the hospital field.

In addition to the foregoing, the personnel of the 1923 National Hospital Day Committee is:

Asa S. Bacon, superintendent, Presbyterian Hospital Association; P. W. Behrens, superintendent, Toledo Hospital, Toledo, Ohio; Rev. P. J. Mahan, S. J., Loyola University School of Medicine, Chicago, acting vice-president, Catholic Hospital Association of the United States and Canada; W. P. Morrill, M.D., superintendent, Charity Hospital, Shreveport, La.; C. W. Munger, M.D., superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich.; George O'Hanlon, M.D., general medical superintendent, Bellevue and Allied Hospitals, New York; F. E. Sampson, M.D., Greater Community Hospital, Creston, Ia.; Mary C. Wheeler, R.N., superintendent, Illinois Training School for Nurses, Chicago; Hugh S. Cumming, M.D., surgeon general, United States Public Health Service, Washington, D.C.; Norman R. Martin, superintendent, Los Angeles County Hospital, Los Angeles, Cal.; Matthew O. Foley, 537 South Dearborn Street, Chicago, executive secretary.

The National Hospital Day Committee has issued the first call for names of hospitals which plan to observe third annual National Hospital Day, May 12, 1923, and will be glad to send to all interested institutions suggestions for a programme and other information concerning the movement. Write to the executive secretary for this material.

*Hospital News

FINISH GERMAN HOSPITAL

Work on the German Evangelical Hospital at Morgan Street and 54th Place, Chicago, is being rushed, following the recent laying of the corner-stone. The building will cost \$350,000 and will accommodate 125 patients. It will serve as an addition to the old Deaconess Hospital, long since grown inadequate. Rev. Joseph A. George is chairman of the building committee of the hospital; William Giesecke is president of the board of trustees and the Rev. H. Brodt is superintendent. German Evangelical churches throughout Chicago will contribute to its support.

*We are indebted to "The Modern Hospital" for the items under this Department.

A Colorado woman, Mrs. Marie Talcott, has leased the building and equipment of Denison Hospital at Denison, Iowa, and is now in charge of the institution. Mrs. Talcott, who is a graduate nurse and a woman of some experience in hospital administration, has had the building redecorated throughout and has made numerous improvements. The Denison Hospital is beautifully situated on a hill overlooking the Boyer river valley.

The new Gary Methodist Hospital, Gary, Ind., which has been under construction for nearly two years was completed early in February. The hospital cost approximately \$400,000. Construction was delayed several times on account of the shortage of funds.

Construction work on the new county tuberculosis sanatorium north of Crown Point, Ind., will be started this spring. It is expected that the building, exclusive of furniture and equipment, will cost \$300,000 and it will accommodate 250 patients.

As a memorial to their daughter, Mr. and Mrs. Harry Bedell of Marion, Ind., recently provided funds for the establishment and equipment of a laboratory in connection with Grant County Hospital. A building is to be remodelled and furnished with new laboratory equipment. It will be known as the Barbara Bedell Memorial.

Miss Anna Bertha Conrad, of the Missouri Baptists Sanatorium, has been selected as superintendent of the new Dickinson County Memorial Hospital, Kansas. Miss Conrad has had five years of nursing experience, including eighteen months in the army nursing service during the war. She was graduated from the Missouri Baptist Sanatorium in 1917 and has served there since in various supervisory capacities.

The Knights of America, a fraternal organization, is soon to build a sanatorium near Panchatoula, La. Accommodation will be provided for twenty-four patients.

ST LOUIS WANTS \$5,000,000 FOR HOSPITALS

Included in a proposed bond issue of \$76,000,000 which city officials of St. Louis, Mo., propose to present to the voters is a \$5,000,000 item for extension and improvement of hospital facilities. The director of public welfare at a recent hearing declared that 300 patients are sleeping on the floors in the City Sanitarium; the City Hospital is overcrowded, and the Kosh Hospital for the tuberculous, built to house 100 patients, is now caring for 1,000. With the \$5,000,000, the city hopes to build an addition to Koch Hospital and the City Sanitarium; to continue the development of the Training School for the feeble-minded; to make additions to the City Hospital; to erect a new morgue, a manual training school for Bellefontaine Farm, a building at the Girls' Farm, a Negro Hospital and a smallpox isolation building.

STATE SANATORIUM OPENS

The state of Mississippi recently opened a modern tuberculosis sanatorium at Magee. The completed plant has a capacity of 960 patients, and the buildings and equipment represent an expenditure of something like \$1,2000,000. The work was begun in 1918 and some of the buildings have been in use for some time. Accommodations are provided for both white and colored patients. The principal buildings are the white infirmary, the service building, nurses' home, power house, laundry, negro infirmary, and administration building. Provision also is made for offices of the field service and extension department. A farm of 388 acres is operated in connection with the sanatorium to provide fresh milk, eggs and other foodstuffs for the patients.

Bids have been taken for the erection of a new sanitarium in Baton Rouge, La., to be known as Our Lady of the Lake Sanitarium.

The Newark Maternity Hospital has purchased a plot, 50 x 260 feet, in Newark, N.J., which it will develop at an early date with a three-storey building, containing 100 rooms.

New York Hospital, New York, has opened a clinic for the treatment of goitre and other diseases of the thyroid gland.

The new United Israel Zion Hospital of Brooklin, N.Y., has as its superintendent, Mr. Boris Fingerhood.

The building of the Laura Franklin Hospital, New York, one of the institutions which consolidated in the new Fifth Avenue Hospital, was recently sold to Dr. Morris Less of New York who will remodel it and conduct a private sanatorium.

The village of Carthage, N.Y., has a ten-bed hospital with the opening recently by Miss Rillia McNeil, a graduate of the Sisters' Hospital in Watertown, of a remodeled residence.

Dr. J. A. McComb, of Springfield, Mo., has sold his interest in the Ozark Sanitarium at that place to Dr. W. R. Summers, his partner. The hospital was founded eight years ago and is for the treatment of persons with nervous and mental diseases.

Freeman Hospital at Joplin, Mo., is to be enlarged by the construction of an annex. As soon as the annex is completed, the hospital plans to conduct a training school for nurses. The proposed improvement will cost approximately \$100,000.

Plans for a new 100-room home for nurses at the Kansas City General Hospital are being considered by the hospital and health board of Kansas City. The cost of the building is estimated at \$100,000. P. J. Morley, architect, has drawn the preliminary plans for the structure.

A two-storey addition is to be erected at the Japanese Hospital, Los Angeles, Cal. The building will be fireproof and modern in equipment.

Formal opening of the new Antelope Valley Hospital at Lancaster, Cal., took place on October 15th, and was largely attended.

Construction work began on the \$250,000 sanatorium to be built in Alameda, Cal. It will be a three-storey building to be erected on the site of the present structure.

Dr. John A. Reily is again superintendent of the Southern California State Hospital at Patton, following his recent resignation as director of the state department of institutions.

The successor to Dr. Edouard S. Loizeaux, who recently resigned as medical superintendent of Sacramento Hospital, Sacramento, Cal., is Dr. Henry Morrison.

Dr. Edward A. Schaper was recently named superintendent and resident physician of the Kern County Tuberculosis Sanatorium at Keene, Cal.

GIFT FOR NURSES' HOME

The directors of the Brattleboro Memorial Hospital at Brattleboro, Vt., recently announced a gift of \$10,000 from Mr. and Mrs. George L. Dunham of that town toward the erection of a nurses' home on the hospital grounds. Mr. and Mrs. Dunham previously had given the hospital \$15,000 toward this home as a memorial to their daughter. The later gift will mean that work can begin at once.

\$250,000 SANATORIUM FOR RICHMOND

A building permit has been issued at Richmond, Va., for the Johnston-Willis Sanatorium to erect a new \$250,000 hospital building. The new hospital building will face the Confederate Memorial Institute, commonly known as the Battle Abbey. It will be six storey high and strictly fireproof.

TO ERECT FRENCH HOSPITAL

Efforts to establish a French hospital either at Pawtucket or Central Falls, R. I., have progressed to a point where interested citizens have organized, collected the nucleus of a fund and obtained a charter from the secretary of state. This institution will be officially known as the Notre Dame Hospital.

RAILROAD PLANS NEW HOSPITAL

A \$150,000 hospital containing 125 beds will be built in Little Rock, Ark., this year by the Missouri Pacific Hospital Association. The building will be three stories high and modern in every respect. The river front along the site of the hospital will be beautiful and the grounds considerably improved. The railroad plans to make the building and grounds one of the most beautiful spots in Little Rock.

Dr. P. P. Salter of Eufaula, Ala., has purchased the old Moulthrop Home on the Bluff at Eufaula and is having it converted into a modern hospital building.

PROPOSE MEMORIAL WING FOR ALBANY HOSPITAL

Friends of the late Dr. M. W. Murray of Albany, Ala., are sponsoring a movement which has as its purpose the erection of a maternity wing to Albany Hospital as a memorial to Dr. Murray. The estimated cost of the maternity annex would be \$50,000. Dr. Murray lived for thirty-two years in Albany and was recognized as one of the leading obstetricians in the state.

Obituary

LIEUT.-COL. ALEXANDER MACKAY

We regret to chronicle the death of one of our editors, Dr. MacKay, Inspector of Provincial Hospitals, who died on the 18th of February, in Wellesley Hospital, Toronto, after a five days' illness from gallstones. The immediate cause of death was heart failure.

Born in Creemore, Dr. MacKay attended High School, and then Trinity University, Toronto. At eighteen he joined the 36th Peel Rangers, which he left in 1916 to go overseas with the C.A.M.C., but later rejoined, being gazetted lieutenant-colonel in August, 1922.

Chief Medical Inspector of the Toronto Public Schools until he went overseas, when he returned, that office was under the jurisdiction of the Ontario Board of Health, so he was appointed Inspector of Hospitals.

Overseas he was M.O. in Orpington Hospital, later going to France, where he was at several base hospitals.

Surviving are his widow, three daughters, the Misses Reno, Beth and Evelyn, two brothers, John C. and W.G., one sister, Mrs. W. J. Jebb, all of Toronto, and his father, who is County Court clerk, as well as local registrar of the County High Court, resident of Barrie.

Dr. MacKay succeeded the late Dr. Bruce Smith, in the office of Hospital Inspector, and was of the same kindly disposition.

Our sympathies are extended to Mrs. MacKay and family.

Book Reviews

How We Resist Disease. An introduction to immunity. By Jean Broadhurst, Ph.D., Assistant Professor of Biology, Teachers' College, Columbia University. 138 illustrations and 4 color plates. The J. B. Lippincott Company, 201 Unity Bldg., Montreal. Price \$2.50.

A scholarly annual, showing both a large knowledge of the subjects treated and a due sense of the requirements of the student entering upon a subject so large and so constantly enlarging. The pupil-nurse can hardly, it is thought, require anything like so extensive an introduction into subjects so abstruse, but for those nurses or others who are specializing in post-graduate directions, the text-book would seem not to be of undue proportions.

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RETIREES FROM HOSPITAL SERVICE

Thirty-one years of continuous hospital service ended last month for Albert M. Conklin, deputy superintendent of New York City Hospital, when he retired in accordance with the New York City Employees' Retirement System. Mr. Conklin's hospital career began on December 18th, 1891, in the capacity of orderly.

On December 20th, preceding his retirement, friends of Mr. Conklin held a reception in his honor at the hospital. Mr. Conklin's successor, Mr. Arthur J. Cote, presided as chairman at the meeting, and addresses were given by various officials. Dr. Charles B. Bacon, medical superintendent, spoke in behalf of the medical and administrative staffs; Miss Theodore H. LeFebvre, principal of the school of nursing, in behalf of the nurses; and C. G. Everett, in behalf of the employees. An autographed testimonial and \$140 in gold were presented to the retiring deputy superintendent.

Immediately following his retirement Mr. Conklin was married to Miss Mary Bell. He has purchased a home in Danbury, Conn., where they will live.

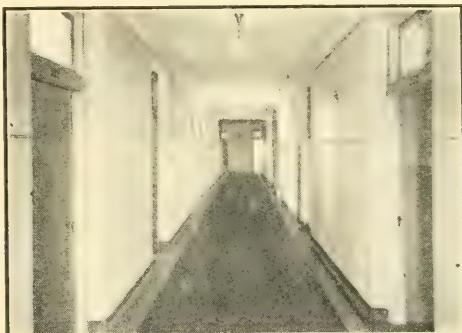
HELP TO PAY OFF INDEBTEDNESS

Citizens of Bangor, Maine, and others interested in hospital work are assisting in paying off the indebtedness of the Eastern Maine General Hospital at Bangor and in providing funds for the constructing of a coal pocket, power plant and laundry. The amount needed for these various projects is \$250,000, much of which already has been raised. With the proposed improvements and the cancellation of interest charges, the hospital hopes to effect a saving of from \$12,000 to \$15,000 annually.

Among the donors were Col. Simon J. Murphy, of Whittier, Cal., who recently provided funds for the erection of the Murphy Memorial Hospital in that town, and "a friend," said to be a stranger in the city who sent a check for \$75,000. Col. Murphy's gift was for \$10,000; he was a former resident of Bangor. Half of the amount needed had been raised in early December.



*Exterior and Interior views
of Royal Alexandra Hospi-
tal, Edmonton, Alta., floor-
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Dominion Battleship Linoleum

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*Folder showing Dominion Battleship in natural colors
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or individuals interested.*



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Montreal**

TO BUILD HOSPITAL IN MEXICO CITY

Convinced that Mexico has regained a strong and capable government, Dr. Aureliano Urrutia, surgeon, has abandoned his practice in San Antonio, Texas, and after touring the United States and Europe will return to his home in Mexico City, where he intends to build a \$1,000,000 hospital and surgical school.

Dr. Urrutia, after studying medicine and surgery in Mexico City and France, became a professor in surgery at the University of Mexico, holding that position for ten years. For two years he was dean of the school and general director of the government hospital. He was in great favor with the Diaz, Madero and Huerto regimes, but came to San Antonio seven years ago, when the political situation interfered with his work.

WORK FOR \$200,000 HOSPITAL IN HUNTSVILLE

A substantial movement is on foot to erect a modern hospital, costing \$200,000, in Huntsville, Ala. Three sites for the building are under consideration and one individual has promised a gift of \$100,000 toward the institution if it is made memorial in character. Another plan being considered by a committee of citizens is the contribution of \$5,000 each for twenty interested persons.

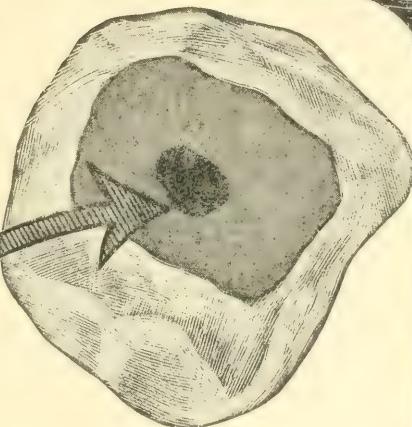
CHANGES IN HOSPITAL NAMES

Changes have recently been made in the names of the following hospitals: Seymour Sanatorium, Banning, Cal., now the Mary Henderson Sanatorium; Heilbron Sanatorium, Bethany, Mo., now Bethany Sanitarium and Hospital; Lakeside Hospital, Seattle, Wash., now North End Hospital.

NEW SUPERINTENDENTS NAMED

The following hospitals have recently announced a change in administrative personnel: Medford Sanatorium, Medford Station, N.Y., Mrs. Marie Hallock; Columbia Hospital, Columbia, S.C., Norwood Greene; Kings Daughters Hospital, Portsmouth, Va., F. A. Bishop; University of Washington Infirmary, Seattle, Wash., Miss Maude Reeder; U. S. Veterans' Hospital No. 78, North Little Rock, Ark., Dr. Edwin P. Bledsoe.

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This "selective" action of

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in inflammatory conditions, may be considered almost "diagnostic."

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TUBERCULOSIS ASSOCIATION TO MEET IN SANTA BARBARA

The National Tuberculosis Association has decided to hold its next annual meeting in Santa Barbara during the week of June 18. Not since 1915, the year of the Panama-Pacific Exhibition, has the meeting been held on the west coast. The annual session will precede the meeting of the American Medical Association in San Francisco and many of the delegates undoubtedly will attend both conventions.

HOSPITALS AND ADDITIONS RECENTLY OPENED

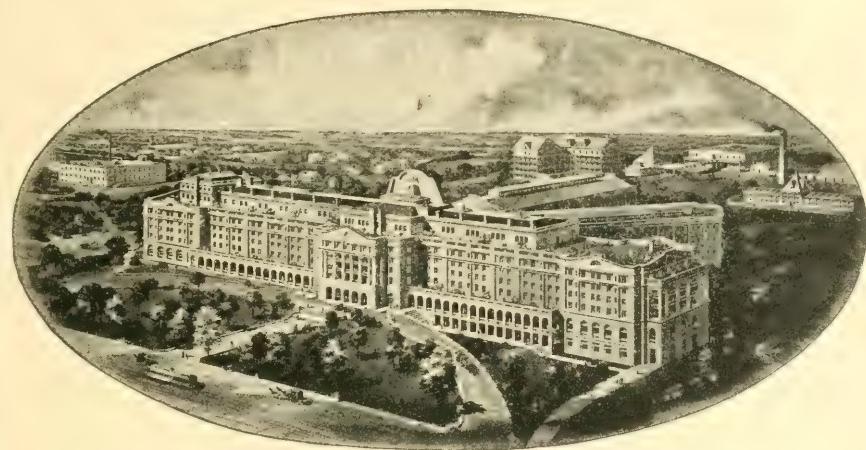
The following new buildings have been recently opened: New maternity wing to be known as the Robert McLaughlin Memorial wing, Oshawa, Ontario, with a capacity of 25 beds; new home for Wesley Memorial Hospital, Atlanta, Ga., 200 beds; new wing at St. Joseph's Hospital, Lewiston, Id., 17 beds; new building, St. Mary's Hospital, DeKalb, Ill.; Mercy Hospital and Nurses' Training School (for colored patients), Cincinnati, Ohio; addition to Methodist Home, Warren, Ind., 22 beds; Fairlawn Hospital, Worcester, Mass., 70 beds; maternity building, St. James Hospital, Brainerd, Minn.; six-storey wing to St. Mary's Hospital, Duluth; three-storey addition to St. Mary's Hospital, Orange, N. J., 150 beds; maternity building, St. James Mercy Hospital, Hornell, N.Y.; addition to Union Hospital, Dover, Ohio, 30 beds; Dr. John B. Leisure's Hospital, Watonga, Okla.; addition to St. Anthony's Hospital, Pendleton, Ore., 50 beds.

TO DIRECT HOSPITAL DIETETIC COUNCIL

The newly organized Hospital Dietetic Council, which is to concentrate its activities upon the special field of the hospital and dispensary, announces the following officers and executive board:

President, Miss Rena S. Eckman, University Hospital, Ann Arbor; first vice-president, Miss Bertha Wood, East Northfield, Mass.; second vice-president, Miss Mary Foley, Mayo Clinic, Rochester, Minn.; executive secretary, Mrs. John Henry Martin, Charles T. Miller Hospital, St. Paul; treasurer, Miss Margaret Fotheringham, Mercy Hospital, Pittsburgh.

Trustees: Miss Margaret Drew, Northern Pacific Hospital, St. Paul, and Miss Irene Wilson, Homeopathic Hospital, Pittsburgh, whose terms expire in 1924; Miss Gertrude Thomas, University Hospital, Minneapolis, Minn. and Mrs. Dorothy Ayers Loudon, 415 Eighth Street South, Moorhead, Minn., whose terms expire in 1923.



An Invitation To Physicians

Physicians in good standing are cordially invited to visit the Battle Creek Sanitarium and Hospital at any time for observation and study, or for rest and treatment.

Special clinics for visiting physicians are conducted in connection with the Hospital, Dispensary and various laboratories.

Physicians in good standing are always welcome as guests, and accommodations for those who desire to make a prolonged stay are furnished at a moderate rate. No charge is made to physicians or dependant members of their families for regular medical examination or treatment.

An illustrated booklet telling of the Origin, Purposes and Methods of the institution, a copy of the current "*Medical Bulletin*," and announcements of clinics, will be sent free upon request.

THE BATTLE CREEK SANITARIUM

Battle Creek

Room 79

Michigan

Laurier—A Study in Canadian Politics. By J. W. DAFOE,
Editor *Manitoba Free Press*. Thomas Allen, publisher, To-
ronto, 1922. pp.182.

This entirely readable little volume is made by issuing in book form four articles originally published in the Monthly Book Review of the *Manitoba Free Press*. The articles were reviews of the much more pretentious official biography of the late Liberal leader, written by Professor O. D. Skelton, of Queen's University, Kingston. The reviewer shows all the qualities with which the more discerning readers of Canadian newspapers have for many years freely credited him, sound judgment, staunch adherence to the sound part of ancestral Liberal principles, a steady sense of fair play, and a literary style unfortunately rare in Canadian journalists.

TRAINMEN FIGHT TUBERCULOSIS

The Brotherhood of Railroad Trainmen, on November 11, started a nation-wide campaign against tuberculosis. Each of the 180,000 members of the union will pay 25 cents a month to the anti-tuberculosis fund. This provides about \$500,000 a year for the campaign.

KELLOGG'S BRAN

Kellogg Company of Battle Creek, confirms the report that the consumption of bran has increased to enormous proportions during the past year. Its sales have been probably without precedent in the time given.

People everywhere seem to have suddenly realized that bran can do more in a natural way to relieve constipation conditions in a permanent way than pills and cathartics.

The important point about the use of Kellogg's is that it is *all bran*—and as you know, *all bran* is a necessity for the effective distention of the intestine, thereby creating better peristaltic action. Another thing about bran that pleases the physician is that it does not create a habit and its usually positive action is free from irritation or discomfort.

Physicians in general are more and more prescribing Kellogg's Bran because it is *all bran*; they can expect results. Again, physicians find that patients like Kellogg's Bran because it is cooked and "krumbled" and most delicious in flavor, making it a pleasure to eat as a cereal, mixed or cooked with hot or cold cereals or used in baking and cooking.

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*Packed in
Two Sizes*



*Domestic Size
makes one pint*

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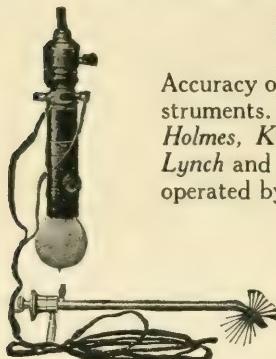
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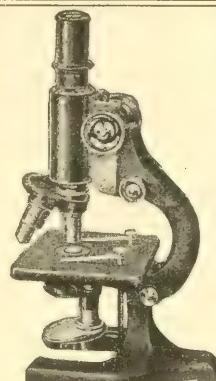
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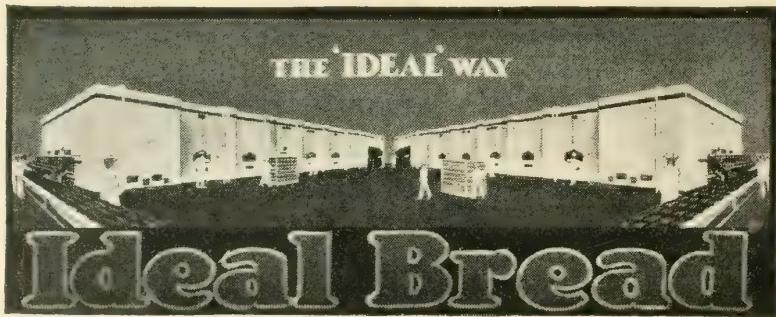
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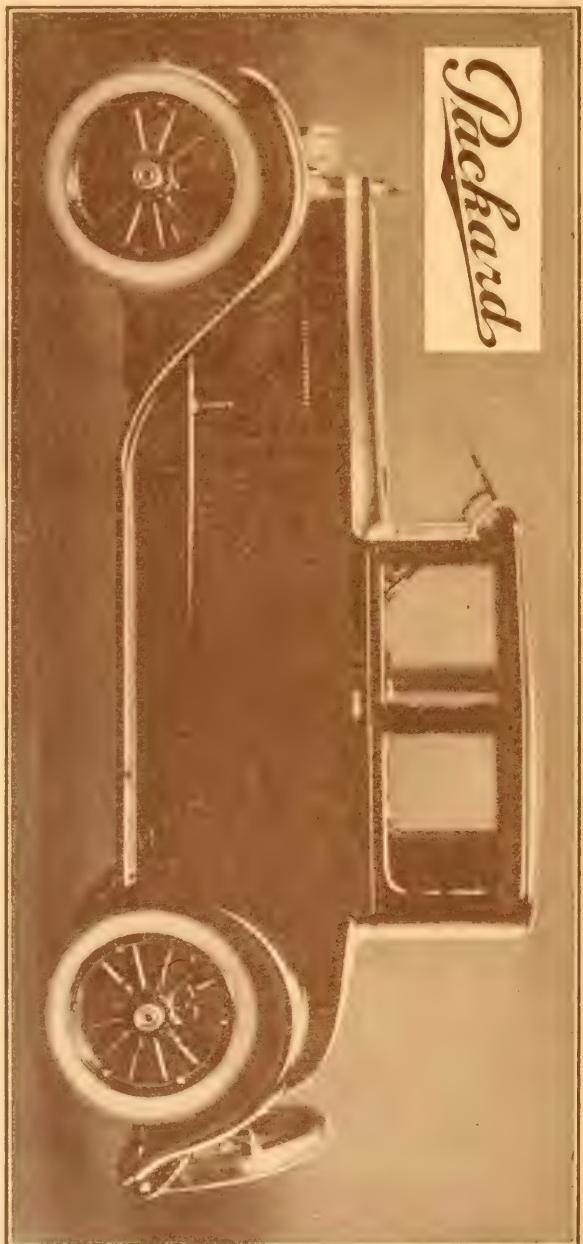
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Vol. XXIII

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No. 6

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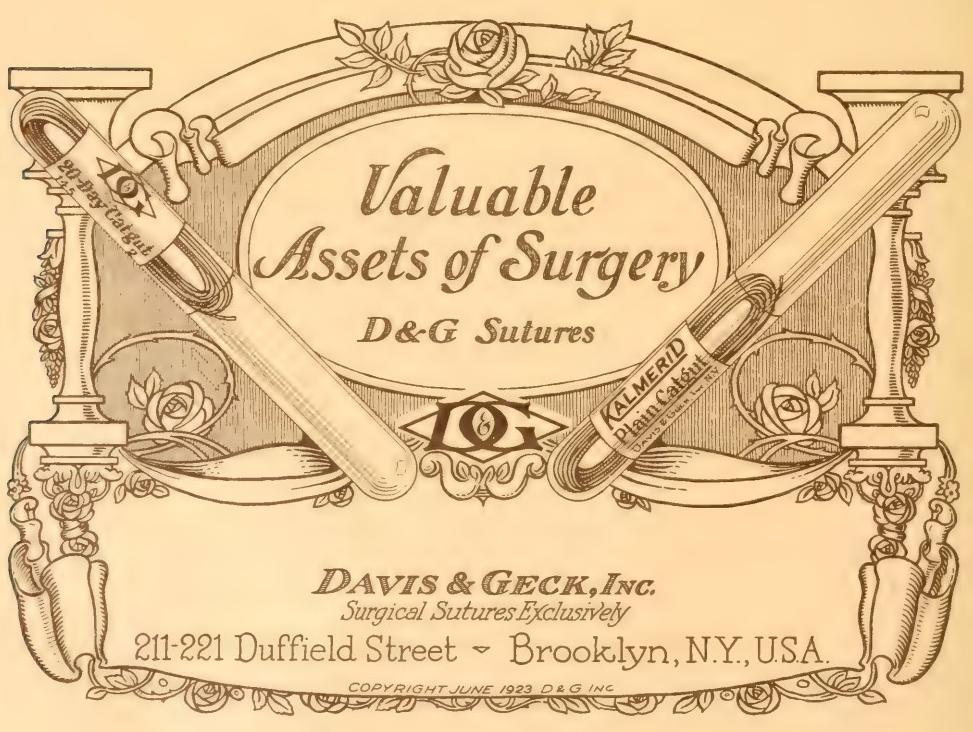
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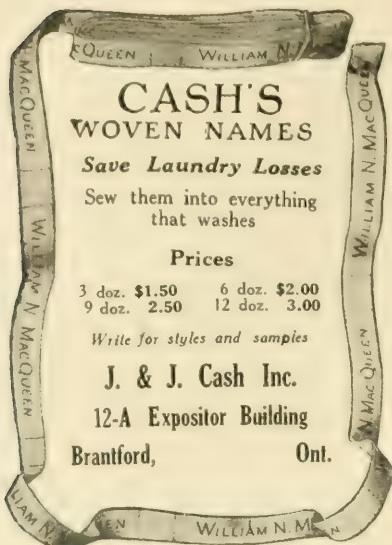
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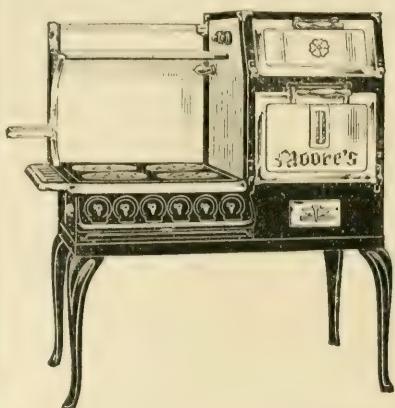
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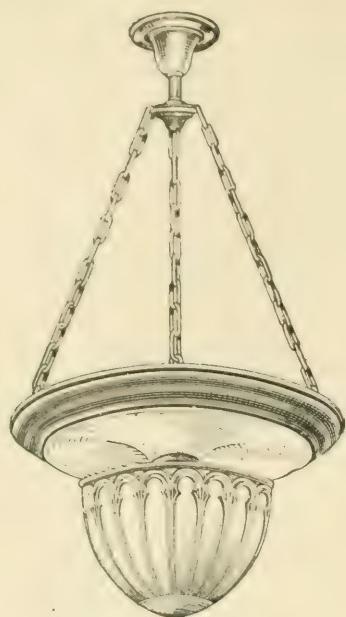
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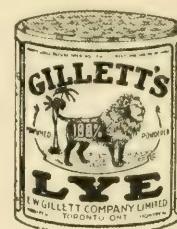
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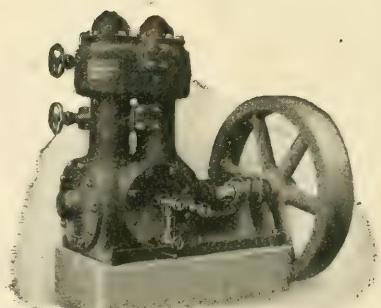
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The Hospital World

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Editorial

Nurse Training

Sister M. Bernice, R.N., of St. Joseph's Hospital, Milwaukee, contributes to *Hospital Progress* an instructive article on hospital training-school problems. She maintains that Sisters should co-operate with student nurses, who should be taught to co-operate with the hospital, the training school and the patient. By co-operation is meant a union of forces, a working together for the same end, all having the same principles. All erroneous self-seeking should be eliminated. When a student is corrected, the principle of the correction should be impressed upon her. She should not get the idea that the correction proceeds from personal feeling of the teacher. Nor must the impression be given that the student has to do a certain thing because the teacher wants it done. She must be taught that teacher as well as pupil must conform their actions to accomplish the same end. A reason should be

given the nurse for correctional action taken. The teacher should not force her method in the pupil by sheer will power and superiority of position. When a student makes a mistake the teacher should wait until her irritability is subsided, think over the matter a little, and then point out the error and why it must never be repeated. A heated reprimand sets a bad example of imperfect control.

Words of encouragement and appreciation should be given to students when they do well.

Both sides of a story should be listened to before corrections are administered. Corrections should not be made in the presence of patients, doctors or others.

Careful study should be given to individual students; they should be approached at the proper angle. They cannot be treated all alike, irrespective of their peculiar traits.

Are we constantly suppressing the student, for fear she will become too forward? Or, do we correct and develop her tendencies, rather than destroy them?

If a nurse timidly makes a suggestion, it should not be smothered. It should be taken up, thought over and then accepted or gently refused.

The teacher should not misuse authority to interfere with student nurses' strictly private affairs. Students should be shown respect. We cannot demand respect and consideration from others unless we give them in generous measure. We cannot force respect from students, but must merit it.

Do students hesitate to come to us and open their hearts, because we make no effort to understand them or consider their point of view?

Can we hope to teach nurses ethics and psychology, if we are not teaching and practising both in our daily lives?

Sister Bernice continues:

"We hear so much about student government; isn't that a nuisance? Should it not be student co-operation? Would students be able to govern themselves wisely? Why not utilize, in co-operation, the forces which the nurse, at the present time, is likely to utilize against us? If students are given a little freedom in expressing ideas to us, are they so likely to criticize when out of our hearing? If we are tolerant and understanding, will they have any reason to feel resentful? The nurses' attitude to us will be patterned very much after our attitude to her."

The Sick Middleman

Sir Alfred Yarrow, who has recently given £100,000 to the Royal Society for the purpose of promoting scientific research, has endowed a convalescent hospital at Broadstairs "for the children of professional and well-educated people in poor circumstances." Prof. Will. Mayo says that he likes to think that in the Mayo hospitals "is one place in God's green earth where the sick man of middle income is as well treated as the sick rich man and the

sick pauper." Both of these gentlemen thus give expression to a generally recognized, and sadly unjust, state of affairs in connection with hospital treatment. Here and there effort is made to rectify the injustice, but in the main we know that it is the sick middleman who bears the heavy burden—one out of all proportion to his means.

For the rich man, sickness is not a pecuniary burden. Equally this is true for the pauper. For the honest, self-respecting, self-supporting rank and file—the people who count in life's onward march—there is no unburdened place in sickness, since hospital nursing and medical costs are away beyond the reach of their average daily living.

This condition has been demonstrated, recognized and discussed over and over again, and yet, thus far, nothing is being done about it except in such isolated instances as the above.

Hospitals are usually crying out for funds. Many of the larger ones are waterlogged with debt. They come annually to the state or municipality to supply their deficit. Yet the cost of treatment to the average sick citizen is so much out of proportion to his means that it constitutes, as Dr. Mayo phrases it, "a heavy burden."

That the hospital is the best place for the sick average citizen is generally acknowledged. The reasons are compelling and obvious. But a large proportion of sick citizens are being inefficiently treated in the home because of the burden of cost.

Physicians know this and would gladly see a way out. A large proportion of our best citizens cannot afford the present cost of hospital treatment. Our hospitals are showing deficits and crying for funds. The problem has not yet been solved.

Hospital Planning

It is important in planning any hospital, to have not only the general features embodied in the plan, but also all the minutiae in so far as possible; because, if construction is once commenced, any alterations afterward are tantalizing and costly. This particularly applies to conduits required for service installations. It is an easy matter to make provision for any equipment if foresight is exercised.

Such apparatus as is required in the kitchen, laundry, laboratories, X-ray department and special rooms should all be indicated in the plans so that "roughing in" may be carried on *pari passu* with the building. To this end it is wise not only to know where the various apparatus are to be placed, but also to know the particular make of apparatus which is to be installed. This may mean that contracts for such apparatus should be made before building operations begin. Often, of course, where funds are short, this plan is not followed: The *corpus* of the building is erected and the equipment contracted for later when funds are available. This course is not ideal; the first suggested above being preferable.

Quite often one make of sterilizer (for example) requires a different sort of roughing in to that which another sort requires. The same may be said of some of the plumbing fixtures. Hence the importance of always deciding in advance, if at all possible, on the particular sort of apparatus, plumbing fixture, laboratory equipment (fixture) or X-ray apparatus which it is contemplated shall be used.

Such foresight often saves hundreds, and, in large institutions, thousands of dollars, and an untold amount of mental friction.

Nurses and Nurses

Much discussion has taken place within recent years on the question of grading and classification of nurses. One element in the profession is totally opposed to any such procedure, insisting that no woman should call herself "nurse" or be allowed to call herself a nurse unless she is graduated from a hospital nursing school where a full term training of two and one-half to three years is given. Any others, they maintain, who care for the sick, i.e., nurse the sick—and they constitute about 75 per cent. of such workers—should adopt the name of "attendant." But this would not "go down;" these underlings would not accept the nomenclature nor would the public who employed them. Failing in this, these nominators hit on the term "nursing aides." (Vide the special Rockefeller report on

nursing). But this effort will be as futile as the other proposal. The second suggestion does admit that these women really do nursing. The terms which have naturally by custom grown up with the work of these women have been "practical nurses" and "experienced nurses." These expressions do not meet with the approval of the powers that be in the nursing world, and we believe that any endeavor to force a name upon a body of women, many of whom are doing a splendid sort of work among the sick who cannot afford to pay five and six dollars a day to a trained nurse, will meet with failure.

We well understand the reason actuating the profession of trained nurses: they fear their field of activity will be trenched upon by these lesser-educated women.

We should like to see these efficient, practical nurses formed into a union for their own protection and the promotion of their own interests.

A New Plan

Mr. Richard Bradley, of Boston, who has done much toward the introduction of a way for the independent family of moderate means to secure adequate nursing service, says that "the hospital trustee and the nursing organization committee should pass around the hat with intensified effort to meet their mounting deficit. Their endeavors, in too many cases, fall short, and have the added disadvantage of undertaking to fulfil a vital function that cannot be adequately discharged by the contribution method. . . . The point of attack is the

business and financial people, who are responsible for hospitals and nursing organizations. What is needed from them is less philanthropy and cheque drawing and more of the business brains that they give to other things. They must organize insurance and benefit payments, so that the people's needs can be met out of their own pockets. . . . They must do this just as they must reorganize the finances of their own hospital and surgery work, so that the ordinary independent citizen can pay for what he needs to have supplied. Otherwise—and they are beginning to know it—they will have it taken over by the state and thrown into politics. In the Missouri Valley Hospital, Kansas City, an attempt is being made to enable people of moderate means to finance their emergency service from their own pockets. . . . It is no more possible to supply the people by our present methods than to pay for their fuel and groceries by passing around the hat, or to expect them to meet the cost of occasional fires out of their current income. The whole therapeutic system is debauched by outworn charity traditions, that impede its true progress."

Mr. Bradley's idea is worth trying out. Who will lead the way in Canada?

The Hospital and Public Health

A good many thinking people maintain that the hospital should be a health centre or a link in a chain of health activities. One such advocate voiced her sentiments at the last meeting of the

American Hospital Association, by saying that such a status of the hospital was desirable and essential because of (1) the prevalence of physical defects in so many people; (2) the place in the family life accorded physicians and nurses by a society still indifferent to its health needs; (3) the scientific equipment as possessed by hospitals and their personnel now used in dealing with health defects, and the increasing use of hospitals in maternity work; (4) the continued and extending use of hospitals as laboratories for the preparation of health workers of various types.

To accomplish this work, this authority maintains that the hospitals will have to re-construct their programmes, methods and systems. The family must increasingly be taken into account if we wish (1) to substantially reduce sickness and death-rates; (2) to progress toward the goal of making every individual a strong, able-bodied citizen over a considerable number of years.

The first step the hospital should take in this direction is to "look to hum."

The entire personnel must experience that sort of life that will impress the essentials of health habits for their personal life, not less than for the lives of the patients, *e.g.*, to start with, consideration should be given to the internes' homes, housing and diet; and the training of nurses in central university schools.

The Insane

For some years our asylums have been crowded. After reading a report of Henry Cotton's work at Trenton State Hospital for Insane, we wonder if similar work might not be carried on in our institutions, with a view of curing a certain percentage of the inmates, thus making room for necessitous cases. It may be claimed that the asylums are undermanned with medical officers. This lack is easily corrected. There are one thousand practitioners in Toronto; it would not be difficult to get twenty of them to go on at each of the asylums in or near Toronto, Queen Street, Mimico and Whitby. These men might represent the various specialties including laboratory and X-ray work. In a few months they would discover in how far Cotton is right when he says that many cases of insanity are due to the presence of foci of infection in some part of the body, the toxins from which are causing the alienation.

In a recent journal we saw it recommended that asylums shall be thrown open to the medical profession to practise in them. Why not? The young graduates now are receiving more or less training in abnormal psychology, and a good few of them serve as "clinics" at these hospitals. These men might well be placed on the staffs of our provincial asylums. Every patient should receive a careful clinical examination, and, in case of discovery of foci of disease in teeth, tonsils, appendix,

sinuses, or where not, these foci should be removed by competent hands. Cotton has had a large percentage of cures.

We commend this plan to Hon. Mr. Nixon.

Pay of Anesthetists

It would seem a poor policy, says Hoag in one of our contemporaries, to go on salary or to allow the hospitals or operators to collect your fee. At the present time those interested in hospital domination of the practice of medicine are using the flat-rate charge and salaried employment to control and socialize the practice of medicine and all its specialties. Salaried positions (the author claims) are being used as part of a wedge game to get the anesthetists in the grip of hospital control, compel them to train nurses and then to let them out by reducing their income and establishing nursing anesthesia as the routine. Such methods, Hoag declares, must be fought to the last ditch or the specialty of anesthesia is doomed to annihilation.

There is every reason, he continues, for charging an extra fee for difficult and prolonged anesthesias, especially when patients can well afford to pay, and, under certain circumstances, it is folly for an anesthetist to leave anyone but himself in charge of the patient post-operatively when life hangs in the balance.

Who Shall Anesthetize?

A writer in a recent number of the *American Journal of Surgery* accuses certain clinics, surgeons, and hospitals of determining to put nursing anesthesia across. To combat this it will be seen that the anesthetists have a large legislative problem before them, if they wish to offset the activities of nursing anesthesia advocates. The writer says that unless political support and financial means are provided to make a legislative fight wherever required, it will be impossible to conserve anesthesia as an inviolable part of the practice of medicine.

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Editors:

ALEXANDER MacKAY, M.D., Inspector of Hospitals, Province of Ontario.

JOHN N. E. BROWN, M.B., (Tor.) Ex-Sec'y American and Canadian Hospital Associations, Former Supt. Toronto General and Detroit General Hospitals.

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MAUDE A. PERRY, B.S., Supervising Dietitian, Montreal General Hospital

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Selected Articles



THE HUMAN TOUCH IN THE HOSPITAL*

E. S. GILMORE, SUPERINTENDENT, WESLEY MEMORIAL
HOSPITAL, CHICAGO.

When a very young man, occasionally I had to pass a hospital and as I looked up at it I used to shudder and think that if only those walls could talk they would say much about suffering, sorrow, neglect, abuse, and medical experiment. In common with most people of the day, I had a special horror of hospitals. The opinion generally of people seemed to be that a hospital was the last step on the way to the grave-yard. This prejudice was founded somewhat in justice.

Hospital managements were quite inclined to believe, since patients came to the hospital not for the fun of it, but because they had to, therefore, it was quite proper they should take their medicine, whether it be drug, knife, or nursing, without demur. The friends and relatives of the patients, who even yet can be depended upon to make more trouble than the patient, were considered legitimate prey for the sarcasm and innuendo of the hospital employees. Visiting hours were limited to one hour a day and one day a week. Apparently, mothers were not supposed to love their children, nor wives their husbands, or, if they did, it wasn't for the patient's good that he be subjected to manifestations of sympathy or that he should receive news regarding the home life he had just left. Something might have happened there to disturb his serenity. Private rooms were few and were an affectation of extreme sickness combined with extreme wealth.

*From a paper read before the fourth Annual Convention of the National Methodist Hospital and Homes Association, Chicago, February 16, 1922.

SOME OLD-FASHIONED PRACTICES

Patients were permitted to die in a ward. The other patients were not supposed to notice this event or, if they did, it was good for their Christian fortitude and gave them opportunity to consider their own souls' welfare and prepare for their own probable deaths. Notices were conspicuously posted commanding silence of all, the better to impress one with the awful solemnity of the occasion. Patients were forbidden to converse with one another concerning their ailments. They might as well have been forbidden to breathe. Nurses were taught, actually taught, that it was unprofessional to give attention to a patient not assigned to the individual nurse. The patient might suffer for a drink of water, but ethics were ethics. Physicians still hover dangerously near this conception of what is ethical.

But hospitals have changed and changed for the better. To-day the properly managed hospital will see that an entering patient gets immediate attention. He will be made welcome and impressed with the fact that his interests are to be uppermost in the thoughts of everyone in the hospital, that his welfare is to be the hospital's first consideration. The necessary office record and financial arrangements should be made promptly and as pleasantly as possible. He should then be escorted to his room by someone, preferably a nurse. The head nurse of the floor should make it her duty to call upon him immediately to answer any questions he may wish to ask and to see that his room is in proper condition. An interne should wait upon him at the earliest possible moment, that he may know his physical condition is under early consideration. A hospital also should be provided with a recreation or living room where patients may go and converse with one another, getting away from their beds and forgetting their troubles temporarily. Hospitals in large cities or hospitals located where restaurant facilities are not convenient, can well afford to have a small dining room for the use of the friends of patients who may be present during the meal hours. This dining room probably will not pay expenses except in an indirect way. No one can compute the value to a hospital of the good will of the patients and their friends. Anything which will make for the increasing of this good will should be adopted.

THE REPUTATION OF THE HOSPITAL

The attitude of the internes, nurses, and employees in the hospital will determine in very large measure the reputation of the hospital. People who are sick physically are usually sick mentally. They may be more grouchy, more unreasonable, and more demanding than when well or they may be more susceptible to sympathy, more desirous of winning the esteem of those about them. In the former case the hospital must disarm suspicion, must overcome prejudice, must win the patient in spite of himself. In the latter case the hospital has an opportunity for doing good that is rarely equalled in any other walk of life. It should be the constant desire of everyone in the hospital so to conduct himself that when the patient leaves the hospital he will gladly say it was good to be there. The hospital management should always keep this in mind and both by example and precept, impress everyone in the hospital with the thought that each patient is the guest of the individual nurse, interne or employee. If each person in the hospital fully realizes that he is the host of the patient and that he should treat the patient as he would a guest in his own home, the hospital has gone a long way towards making the patient happy and increasing its own popularity.

No hospital management has a right, however, to expect that this condition will exist automatically in the minds and hearts of the hospital personnel. It is the business of the management to implant it by seeing that the conditions in the hospital are such as to make the helpers thereof part of the hospital and desirous of doing all they possibly can to assist the patients. This means the best possible accommodation for the nurses, for the internes, for the help. The time once was that the nurses were domiciled in some nearby dwelling house that had been converted into a nurses' home by the simple expedient of setting aside the parlor as a reception room and then crowding the nurses into every other room in the house, including the kitchen and pantry, filling each room with as many beds as it would hold. The employees were usually housed in the cellar and the attic of the hospital, generally called "basement and top floor," to salve the conscience. The internes were crowded into just as few rooms

as possible and were generally impressed with the idea that they were not physicians and men, but incorrigible boys, who could always be expected to do the wrong thing at the right time.

ENTITLED TO GOOD LIVING CONDITIONS

All these people, internes, nurses, and employees, are entitled to the best living conditions the hospital can afford. You may be sure the patients will receive exactly the same kind of treatment that the hospitals give to those who care for the patients. If the nurse, for example, is well housed, well fed, contented, if she receives thoughtful consideration, if she gets a thorough training and is treated as a woman, in the very nature of things her soul will sing within her and the patient will receive thoughtfulness, sympathy, and intelligence mixed into his care. If, on the other hand, a nurse receives none of the things which make her happy and contented, but is made to feel that she is a child, more or less under suspicion, unless she is a moral phenomenon, she is going to work out her moods upon her patients. A hospital may not justly expect to recruit into its ranks none but moral phenomena. The best way to get the golden rule into the hearts of the hospital personnel is for the hospital management itself to adopt the golden rule and live by it.

HOME-LIKE CONDITIONS AN ASSET

It has been divinely said, "man does not live by bread alone." It is equally true that man does not live by sympathy alone. It is the duty of the hospital to see that meals are well prepared and well served, being as warm and tasteful as possible. The rooms should be made home-like. The days are past when the medical profession felt that germs were roosting on the picture frame, the curtain, etc., just waiting for an opportunity to jump off on to the patient. The medical profession is now convinced that the pleasant surroundings of the patient will go far towards aiding in his recovery. Walls should be pleasantly decorated, windows prettily draped, furniture suitably designed, and floors covered with rugs. One should get as far away as possible from the institutional idea and make everything as home-like as hospital conditions

will permit. It is taken for granted that the hospital will have all proper laboratory facilities for skilful, scientific care of patients, else it is not a hospital.

It is my belief that the hospital superintendent cannot do better than to set aside a portion of each day for the visitation of patients. This takes time, but time can be found if the superintendent resolutely determines to find it. Some patients still come to a hospital with a chip on their shoulder, expecting to be misused and ill-treated, laboring under the thought that the hospital desires only their money. If such a patient is called upon the day of his arrival by the superintendent and in a few words given to understand that it is the hospital's desire to aid him in his recovery in every way possible, making his surroundings pleasant and giving him the best of attention, he is at once disarmed and he says to himself that things may not be as he had expected.

If that visit is repeated every day in only a short time the patient looks forward to the coming of the superintendent and there is a warm personal feeling existing between the two. Grievances are no longer nursed by the patient, but unless important, are quite likely dismissed with the thought that the untoward happening is not in accordance with the wish of the hospital, but against it. If, however, the grievance is of sufficient importance to warrant attention, the visit of the superintendent gives the patient opportunity to make known his objections directly to the superintendent, and the trouble, whatever its nature, can be adjusted easily and amicably. The fact that the superintendent makes daily visits also is known to the personnel of the hospital and the knowledge that any dereliction on its part will come to his attention, makes for better service. But by far the most important thing is that the patient feels someone in authority is interested in him and his heart will glow with appreciation and into his mind will steal a sense of relief, aiding materially in his recovery. Hospitals have it in their power to do much to make this old world better.

Another thoughtful thing for hospitals to do is to provide complimentary meals for an immediate relative of each patient at Christmas time, Thanksgiving, New Year's, or on a wedding or birthday anniversary. This may not be possible

in crowded wards, but it is possible in private rooms and a day which might otherwise be given over to self-pity and the sorrow consequent upon absence from a loved one at a time generally given to family reunion becomes a day of exceptional pleasure and lives many years in memory.

DON'T FORGET DISCHARGED PATIENTS.

Patients ought not to be forgotten immediately they leave the hospital. It is pleasing to the patient and is of value to the physician, for the hospital at some stated time, say three months after the patient has left, to send a letter or return postal card to the patient asking after his present condition, if his operation or treatment has proved successful, if there are any complications, etc. This affords the patient a welcome surprise in the thought that the hospital is still mindful of his interests and it affords the physician a check upon his effectiveness.

A hospital doing any considerable amount of work among the poor should also have a social service department. A nurse from this department should visit the homes of the poor while they are in the hospital to see that those left behind are properly cared for and to aid them, through charitable organizations, when they stand in need. She should also visit the patient occasionally upon his return to his home, to see that he is making good recovery or in the event of a return of his trouble or complications, that he is returned to the hospital for further treatment.

Towns large enough to have a hospital are large enough to have a library. There should be no difficulty in making the hospital a branch of the library. The latest books can then be taken to the patients at their bedsides, and many an otherwise weary hour may be profitably and pleasantly spent.

These are some of the things which make hospital service something more than a means of earning a livelihood.—*Hospital Management.*

ROYAL VICTORIA HOSPITAL'S METABOLISM SERVICE*

E. H. MASON, M.D., AND H. E. WEBSTER, SUPERINTENDENT,
ROYAL VICTORIA HOSPITAL, MONTREAL, CANADA.

The metabolism service of the Royal Victoria Hospital was organized in 1917 and housed in a remodeled separate building previously used as an isolation ward. This building is connected to the hospital by a short, covered corridor at the



The metabolism service at Royal Victoria Hospital is housed in the small ward in the foreground, formerly used for isolation purposes. It is connected to the hospital by a short covered corridor.

central part of the main building, thereby making the ward convenient to all parts of the hospital.

The general appearance and floor space is well shown in the accompanying photographs. In detail the total floor space is divided as follows:

*We are indebted to "The Modern Hospital" for the use of the half tones appearing in this article.

Through the centre of the building there is a main corridor with rooms opening upon both sides. At the back is the laboratory. The respiratory laboratory, a part of the metabolism service, is located in another part of the hospital, at a point convenient for the transfer of bed patients.

The division is as follows:

- 1 office.
- 3 private rooms (1 patient per room).
- 4 public rooms (2 patients per room).
- 1 kitchen.
- 1 dispensary and instruction room.
- 2 bath rooms.
- 1 scale room.
- 1 linen room.
- 1 laboratory.
- 1 stock room.

The kitchen is twice the size of the bedrooms. The laboratory extends off to one side from the end of the ward, opening into the main corridor. Across from it is the stock room. The dispensary is the size of a bedroom and in addition to its use as an outdoor diabetic clinic, it is employed four mornings each week for instruction.

The personnel working on the service consists of: one doctor, full time, in charge of the service; one doctor, half time, in charge of diabetic instruction; one resident house officer, full time; two girl technicians; and one laboratory orderly.

The day nursing staff consists of one head nurse and three nurses in training. On the night staff are one nurse in training and a ward maid.

The total personnel consists of twelve workers, all except one being full time. This makes more than one per patient, the maximum number of patients that can be accommodated being eleven.

The equipment installed outside of the regular hospital equipment is as follows:

Kitchen.

- 2 Chatillon food scales No. 126½, 500 grams.
- 1 steamer for vegetables.
- 1 Torsion balance.
- Individual dishes.
- Granite cc. measuring cups.

Ward.

- 1 Scale, (height and weight).
- 1 typewriter.
- 1 telephone.
- 1 ophthalmoscope.
- 1 blackboard (dispensary).

Laboratory.

- 1 water still.
 - 1 electric hot air oven.
 - 1 Kjeldahl digesting stand.
 - 1 Kjeldahl distilling stand.
 - 1 steam water bath.
 - 1 set of six electric plates.
 - 1 ice box.
 - 1 autoclave.
 - 1 centrifuge.
 - 1 barometer.
 - 1 microscope.
 - 2 Duboscq colorimeters.
 - 1 fine balance.
 - 1 balance.
 - 2 vacuum pumps.
 - 2 Van Slyke CO₂ apparatus.
- Usual glassware, porcelain ware, stands, tripods, etc.

Basal Metabolism.

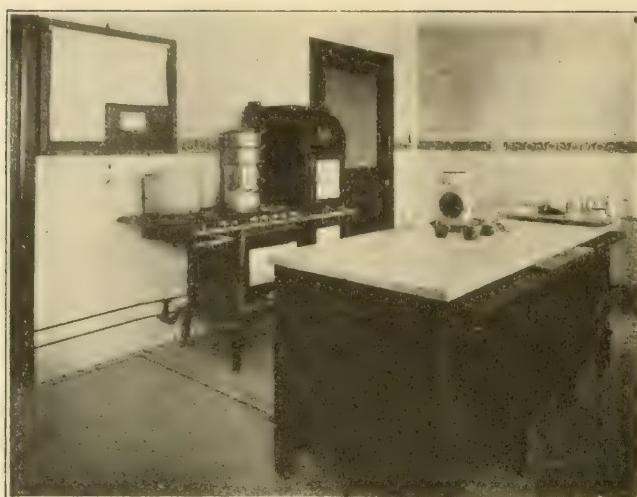
- 2 sets metabolism apparatus.
- 1 Tisot gasometer.
- 2 gas analysis apparatus.
- 1 barometer.

TYPE OF WORK UNDERTAKEN.

To date, the main function of the metabolism service has been to handle all cases of diabetes mellitus admitted to the hospital. In addition extensive studies have been made on a large series of nephritic patients, and at times others problems have been investigated, such as the fasting treatment of epilepsy and special dietetic treatment in various types of hyperthyroidism. Further, an interesting series of obesity cases have been handled and chemical problems in many isolated diseases have been studied. The laboratory, in addition to handling all the work from its own ward, does all the blood chemical determinations for the other wards of the hospital, both private and public.



Two views of the laboratory (left and right) and a corner of the dispensary and room for instruction (centre).



The metabolism service kitchen

The respiration laboratory completes all the basal metabolism determinations for the whole hospital, the thyroid work being done in close combination with a thyroid group which has been functioning for the past year.

The metabolism service uses several forms which are peculiar to its department, being as follows:

In ward:

- Large laboratory record sheet.
- Daily diet form.
- Kitchen sheet.
- Food value sheets (for instructions).

In laboratory:

- Daily urinalysis sheet.
- Nephritic test meal report.
- Urea and chloride excretion report.

In respiration laboratory:

- Test sheets (2).
- Basal metabolism report.

In dispensary:

- Case record.
- Weekly report sheet. (Entered upon main record and then destroyed).

INSTRUCTION OF PATIENTS EMPHASIZED.

A special effort is made with all diabetic patients to teach them so that upon their discharge they are able to figure diets upon ordered food values, examine their own urine for sugar and the acetone bodies, and prepare weighed diets. Also some knowledge of their disease is given to them so that they will appreciate the importance of living upon a weighed diet. In our experience diabetic patients do well largely in proportion to the thoroughness of their education. Upon discharge the hospital provides them with the following equipment, for which they pay:

- 1 Chatillon food scale No. 126½, 500 grams.
- 1 granite cc. measuring cup.
- 6 test tubes.
- Fehlings solution.
- 5 per cent. ferric chloride solution.

The organization, as previously outlined, has been found to work very satisfactorily. Our staff is busy all of the time and will have to be enlarged if the department expands. The main fault in the floor space is that the laboratory is not large enough for the work undertaken.—*The Modern Hospital.*

CHOOSING THE ANESTHETIST

ISIDORE JOSEPHSON, M.D., NEW YORK.

Ever since general anesthesia was first introduced into surgery the choice of an anesthetic was the field of experimentation and investigation. At the present day the value of each has been tested and proven, and the choice of one for a certain operation and patient is easily determined. The value of ether, chloroform, nitrous oxide, ethyl chloride, etc., as a general anesthetic has been fully determined and very little can be added in our present state of knowledge.

Choosing the anesthetist to decide whether it shall be the nurse or the intern, the experienced physician or the novice, is a matter still in the experimental stage.

A well known surgeon once said that if he were to be operated on his first question would be, "Who is going to be my anesthetist?" The apprehension which the layman experiences as regards his anesthetic is only too well known, and

the majority fear this part of an operation more than the operation itself, the surgeon himself, more than anyone else, appreciating the importance of the anesthetiser. In spite of this, this important task is often entrusted to some underling, who pursues his task unconscious of its importance, and it is surprising that so many surgeons tolerate this.

Anesthesia, as an art and science, is a comparatively new study and it is only within recent years that it has been elevated into the realm of specialties. Thus there are now specialists in anesthesia just the same as there are specialists in any other medical specialties. Numerous books have within recent years been written on the art and science of anesthesia, and the literature on the subject is voluminous—for the administration of the anesthetic is become more and more to be considered next to, if not of as equal importance, as the operation.

Now the practice of any specialty implies a preliminary thorough groundwork in general medicine. In spite of this fact the administration of an anesthetic is often entrusted to individuals who have never even seen the inside of a medical school, particularly the trained nurse, and working on the supposition that anesthesia is a specialty of medicine it is hard to understand why the trained nurse, after more or less instruction in anesthesia, should be permitted to practise this specialty. Surely no one would expect a trained nurse or any other non-medical individual to become a competent ophthalmologist or gynecologist or specialist in any other branch of medicine, no matter how extensive the period of training nor how competent the instructor. P. J. Flagg, in his preface to *The Art of Anesthesia*, says: "How can a lay person intelligently form an opinion upon such vital matters as acidosis, toxemia, carbon dioxide, stimulation and depression? How can he unravel and relieve the untoward symptoms which might arise in a case complicated by respiratory obstruction, morphine depression and reflex inhibition?" No one can deny that these factors must constantly be uppermost in the mind of the individual officiating at the head of the table if he is really in earnest about his work, but earnestness does not imply a medical education.

There is one other medical specialty practised extensively by non-medical individuals, and which can be given here in comparison, namely, obstetrics. We all know of the havoc wrought by the midwife. The medical profession is beginning to realize the gravity of permitting poorly trained women to attend a woman in labor, a procedure that sometimes assumes the proportions of a major operation. Shall the science of anesthesia also be permitted to be practised by those who are not competent?

The fault, no doubt, lies in the fact that in both cases some degree of mechanical skill is involved, a skill easily acquired, but with forgetfulness at the same time that there are a great many fundamental principles of medicine and surgery at the bottom. An individual cannot be called an anesthetist when just able to guide a patient through an anesthetic by virtue of certain signs which he has been taught to recognize, any more than a woman who has been taught how to make a vaginal examination and can guide the head over the perineum without getting a tear, can be called an obstetrician.

The medical man to whom the ether cone is most often entrusted, is the hospital intern. The advantage in having the intern administer anesthetics is that he possesses a medical training. Still, there are some disadvantages unless his work is supervised by competent anesthetists. Most hospitals do have regularly appointed visiting anesthetists, for the purpose of acting as instructors to the interns, and the system would be ideal were the instructor always present on operating days. He very often fails to make his appearance and the intern is left to get along as best he can. I maintain that no intern should be permitted to administer an anesthetic without the presence of the visiting anesthetist. Since no house surgeon is permitted to perform an operation without the presence of the attending surgeon, no exception should be made as regards the anesthetist.

A surgeon who is constantly diverted from his task in worrying about the anesthetist, cannot give full measure of his skill to his patient, and without co-ordination between surgeon and anesthetist the patient is deprived of both their individual attention, the burden most often falling upon the ward patient.

The average intern when left to his own resources, and after having overcome the first difficulties of his art, acquires a certain degree of contempt for this part of his training, whereas the more experienced and thoughtful man ever acquires a greater respect for his work. To quote Flagg again: "A thousand anesthesias instead of leading to crudeness should make one a thousand times more careful." The intern, however, considers this part of his training as something to be soon over, and it is a common thing to hear interns say, when speaking among themselves, that they are tired of "slinging dope." It takes a great deal of experience and practice to become an expert anesthetist. The intern changes his service every three or four months. Just about the time the surgeon is beginning to have confidence in one man, his service changes, and the surgeon finds a new one to cope with. Naturally every surgeon expects good work, and many surgeons are cranks on anesthesia, and properly so. The poor intern is, of course, crude in his work, and is often the butt of the surgeon's remarks. The latter forgets that the intern is placed in a peculiar position, namely, that of a novice endeavoring to do the work of an expert.

My chief argument is in behalf of the general ward patient, who is the usual one to suffer. The private patient can choose his own anesthetist. The surgeon usually sees to it that only an experienced man will act in this capacity for his private cases, for it is a great source of comfort to him. But the patient in the general hospital ward has no choice in either operator or anesthetist. As far as the surgeon is concerned no patient need fear, for most surgeons on the attending staffs of our free hospitals are appointed only after demonstrating their worth. The same should apply to the anesthetist. Nurses as anesthetists should be entirely eliminated. An intern should act in this capacity as part of his training only in the presence of and under direct supervision of the attending anesthetist. In this way the surgeon's peace of mind would be preserved, the operation pursued with greater despatch, and the patient's welfare thereby safeguarded.—*New York Medical Journal.*

HOSPITAL SERVICE IN THE UNITED STATES

Statistics have been published (*Journal A. M. A.*) regarding 6,152 hospitals, sanatoriums and related institutions in the United States. The figures are based on reports from superintendents, directors or other executives of the hospitals or of the government hospitals, from the officers who are in position to give the facts.

The statistics deal mainly with the most important group of hospitals: the private, general or special hospitals open to the public for the general care of the sick. A list of the 2,926 having twenty-five or more beds each is published, in which, for each hospital, are given the name of the institution, the name and population of the town or city and the name of the county in which it is located, the total bed capacity, and the average number of beds in use. There are also, 1,087 hospitals in this group which have less than twenty-five beds each. The names of these are not published, but the total number in each state is given, together with the total bed capacity and the average number of beds in use. Following the list for each state are given the number and names of the counties in which there are no hospitals for the general care of the sick.

Of the 2,926 hospitals providing general service having twenty-five or more beds, 483 have been approved for the training of interns. The fact that a hospital is not approved for the training of interns should not be misinterpreted to mean that the hospital is not providing satisfactory care for its patients. On the contrary, there are many hospitals rendering a very excellent service to their patients, which do not seek or utilize interns, and which are undoubtedly worthy of approval as non-intern hospitals.

Four factors must be considered in the study of these statistics to determine accurately whether or not a district, state or community has an adequate supply of hospitals. These are the ratio of square miles of area to each hospital; the ratio of hospital beds to population; the percentage of beds on the average in use, and the percentage of counties which have no hospitals. There are at present 4,013 of these hospitals in the United States with a total of 311,159 beds—one bed

to every 340 persons—and of these beds 206,024, or 67 per cent. are in use. There is one hospital on the average to every 741 square miles, ranging from one to every 42 square miles in Massachusetts to one to every 5,780 miles in Nevada. The situation in Nevada appears to be less serious, however, than in Mississippi, where there is one hospital to every 1,104 square miles. The latter state is more thickly populated and has only one hospital bed to every 1,054 persons, while Nevada has one bed to every 139. Of the 3,027 counties in all states, 1,695, or 56 per cent. have no hospitals. The North Atlantic district is fairly well supplied with hospitals as compared with the South Central and the Western districts. But a study of the figures shows that in the North Atlantic, as well as in other districts, owing to a poor distribution, some portions have an abundance of hospitals.

As to the adequate proportion of hospital beds to population, estimates by hospital experts state that there should be one bed for from 300 to 500 persons. These statistics show one bed to every 340 persons; but since fifty-six per cent. of all counties are without hospitals, it is evident that the distribution is at fault. With a proper distribution, furthermore, it is probable that the proportion of beds in use would be much larger than sixty-seven per cent. as shown in the statistics. Another evidence of poor distribution shown by these statistics: For example, an investigation of the supply in Delaware shows that the seven hospitals in that state are all located in the extreme north end—a part where the public has also the easiest access by rail to the hospitals of Baltimore and Philadelphia—while four-fifths of the state have no hospitals.

The lesson to be learned from these figures is that in the establishing of hospitals hereafter, communities should be selected which are not already abundantly or over-abundantly supplied. These statistics will be of service in showing which communities are in greatest need of hospitals.

THE DUTY OF THE DOCTOR TO THE NURSE

W. L. HELMS, TAYLOR, TEXAS.

At first thought it seemed this subject would be a very easy one to discuss, but the more thought that I have given it the more difficult it seems to be. It is a subject upon which nothing has been written, therefore I could refer to no bibliography for aid. What I shall say is therefore entirely original and some of us have very little originality.

In various books on nursing ethics we find there is plenty written on the duty of the nurse towards the doctor. It seems that there has been a great amount of thought about this special duty of the nurse, but very little of the doctor's duty toward the nurse.

Nursing is to be looked upon as a profession and an honorable one. The time was when the nurse was thought of as a kind of servant, was not respected as a member of an honorable profession, even in the minds of many was considered a "questionable" character, but conditions or sentiment, I rather believe, has changed so materially that we have entering our training schools and through them into the nursing profession as noble, intelligent, pure and accomplished girls as enter any other profession or calling in life and they are more appreciated now by both the medical profession and the laity than ever before. They are welcomed into the best of homes with a heartiness equal to any.

Sometimes yet, however, the family fails to understand the duties of the nurse and expects many things of her that do not pertain to her duties toward the patient. The doctor should, in a tactful way, try to correct such erroneous ideas and protect the faithful nurse in every way possible. A nurse should not be criticized in the presence of others. It is very rarely necessary to reprimand one and should criticism become necessary we should exercise the fine art of finding fault pleasantly.

We should express appreciation of the services rendered by the nurse. Many times, as each of you well know, an expression of heartfelt gratitude is a greater reward and is appreciated more than any monetary remuneration.

One should see that the nurse gets a sufficient amount of rest. For one to do her best work it is necessary that she should be allowed to get plenty of sleep and time to divert her mind from the nursing duties each day.

Many of the mistakes charged up to nurses and the inattention to the little details of nursing are no doubt due to long hours of work. However, in our loyalty, should one prove to be unreliable and untrustworthy, she should not be upheld.

A nurse in charge of a case should be informed of the nature of the case and the treatment used. She should, in case some special treatment is being pursued, be informed of what the physician is expecting to accomplish and forewarned of any complications that are liable to arise. This, of course, in order that she may be better prepared to anticipate and meet such complications as they arise.

The duties of the doctor to the nurse after all, may be expressed in this simple phrase, "treat her right." She is a great help to the physician in many ways and not infrequently is she able to help the physician to keep his impatient disgruntled clients, who without her influence would shift to another doctor. She is in every way worthy of our respect, co-operation and support.—*Practical Medicine and Surgery.*

FAULTS IN OUR SYSTEM OF TRAINING NURSES

The demand of the army for nurses is draining trained nurses from civil hospitals and from private practice. The proposal of Doctor Goldwater that provision be made for training volunteer nurse aids in the nurses' training schools, while good, does not go far enough. The trouble is fundamental and to cure it would involve a complete revolution in our nursing curriculum.

The present system of training nurses is radically wrong in two respects. The length of time spent by the pupils in training is too long, and the cost of the training to the hospitals is too high. If the curriculum for the trained nurse were

dissociated entirely from the question of maintenance for the nurse and was placed upon a businesslike, and at the same time scientific basis, it would be found that two years would be ample in which to train a nurse for registration.

Such a curriculum would require more hours of study by the nurse, a better type of instruction than is given in many institutions, and would involve a greater outlay than is usually allotted for the conduct of the training school. For this instruction the nurse should pay a moderate fee. The training school should not be required to house or feed the pupils without charge. The best solution of the problem might be the requirement that the pupil should pay for her board and lodging at about cost to the institution, and pay a fee equivalent to about the cost of maintaining a teaching staff, being in turn paid for the number of hours of service rendered to the institution; the rate of this pay being changed every six months commensurate with the value of her services.

A somewhat similar method is followed in some of the State agricultural colleges. There tuition is furnished free by the State, the pupil pays for his board and lodging at actual cost, and this is very little, and is given an opportunity to put into practice what he is being taught, by laboring in the fields, the hothouses, the gardens, or the stables of the institution, and is paid by the hour for the amount of time devoted to doing this.

The advantage of such a general plan would be that there would be a clearer comprehension of the relation of the different phases of the nurses' training to each other and of the nurses to the institution.

Such a two years' course would afford ample time not only for the basic general training of the nurses but for the specialization in the particular field in which the nurse proposes to enter.

One of the basic difficulties under the existing system is the confusion of issues brought about by the practice of paying nurses, or at least of supporting them during their tutelage. In order to recoup themselves for this expense, the hospitals require of the pupils much menial labor which should

be performed by maid-servants drawn from a wholly different class from that which supplies pupil nurses. Such a reorganization of our system of instruction would bring into the field a great many desirable pupils of superior intelligence who are now shut out of this work by a curriculum which involves an excessive amount of purely menial service.

Of late there has been much criticism of the tendency to expand the curriculum along purely theoretical and scientific lines which have no immediate bearing upon the duties of the nurse. Much of this criticism is undoubtedly well founded. But the main trouble with the curriculum is the confusion of issues which is incident to the erroneous system now followed of paying pupil nurses and making them earn this pay by doing menial labor ostensibly as part of the necessary drill.

—*Selected.*

PIGS IS PIGS

BUT THE KIND REQUIRED TO KEEP LADY PATIENTS WARM
STUMPED THE NEW HOSPITAL ORDERLY.

D. A. McGREGOR.

A new and entirely original demonstration of the old theorem that "pigs is pigs" was furnished, quite unconsciously, a short time ago at the big Hospital for Consumptives at Tranquille, near Kamloops. The hospital, which is situated in the British Columbia "dry belt," emphasizes very strongly the open-air treatment. In the great wards there are windows everywhere and they are always open. The weather is always bright, and even in winter usually pleasantly warm, but the patients are encouraged to endure the coldest spells without retiring to the unhealthy atmosphere indoors. There is heat in the buildings, of course, but that is partly for the sake of appearances and partly to keep the water pipes from freezing. The patients are not supposed to have any interest in it.

A week or two before Christmas winter descended on the West with unusual suddenness and severity, and there was much shivering about the sanatorium. In the women's ward a call went up for more comforters, and an orderly was despatched post haste to the administration building for a "pig"

for each bed. The orderly was a new man, who had not yet acquired a command of hospital slang, and, seemingly, at the administration building, he encountered a clerk who was in the same condition.

"No, we have no pigs here," he was told. "Wonder what they can want them for?"

"The ladies are cold," the orderly confided. "The nurse said I was to bring a pig for each."

There was some further discussion of the situation, and then a great light dawned on the clerk.

"The nurse must mean guinea pigs," she decided. "They have a lot of them over at the laboratory."

So through the snow to the laboratory Mr. Orderly tramped. There wasn't anyone about to interfere with him. So he selected a warm, fat guinea pig for each shivering lady patient, and, with his trophies in a sack, started back to the women's ward to play Santa Claus.

It is too bad to spoil the story. But the furry little animals never reached the ladies' beds. One of the ubiquitous head nurses caught the messenger in one of the corridors, boxed his ears metaphorically, and sent him scurrying back across the snow for a load of stone hot-water bottles.

Items*

SUPREME COURT DECISIONS

A recent decision of the supreme court of Ohio upholds what is known as "the pay-patient law," the claim being made by Hamilton County that the law is unconstitutional, violating the rights of the defendant.

The sections of the general code (1898 Art. 1815-12) in force during this period of the proceeding, provided specifically "that the cost of support of any county's inmates at the institution for feeble-minded youth should be charged against such county," presenting the manner of requisition and payment.

It is contended that the provision violates the state constitution reading, "Institutions for the benefit of the insane, blind, deaf, and dumb shall always be fostered and supported by the state; and be subject to such general regulations as may be prescribed by the general assembly."

It was contended that the state is ordered to support such institutions and that the legislature can neither authorize nor order a county to levy a tax to meet the expense.

As early as 1822 in the state the constitutionality of a somewhat similar provision was challenged. Since that decision "provisions have been enacted requiring persons liable for the support of one committed to such an institution to pay a portion of the expenses of the maintenance of such a person, but, in the case of indigency, the several counties are required to make payments for the maintenance of persons committed therefrom to such institutions. If the requirement that individuals liable for the support of a person committed pay a portion of the expense of maintenance, or that it be realized out of the property of such person himself, is not in conflict with the constitutional provision referred to, it is difficult to see how a requirement that in the event of indigency the county from which the patient is committed shall bear such expense, is violative of such constitutional provision.

*We are indebted to *The Modern Hospital* for these items.

The institution is fostered and supported by the state, notwithstanding the requirement that those able to support and liable for the support of a patient committed thereto be required to contribute to such expense, and that where such conditions do not obtain the county from which the patient is committed be required to do so."—*State vs. Hurve, 137 N. E. 167.*

The supreme court of the Mississippi on November 21, 1922, stated that the "hospital conducted for private gain is liable for injuries to a patient resulting from the negligence of its employees. The business of such a hospital carries with it an implied obligation to give the patients therein reasonable care and attention."

It seems that a child of eight who had an attack of appendicitis was taken to the hospital for care and was there operated upon. Shortly thereafter when there was no attendant in the ward, she fell off the bed on which she was lying and soon after died. The court adds that the liability of the appellee is a question for the jury to decide and consequently a previous decision was reversed and the case remanded.—*Maxie vs. Laurel General Hospital, 93 So. 817.*

The hospital in this case, prior to 1921, was managed by five trustees, three officers being ex-officio members, and two being selected from the employees by the president. That year an action was brought by the state against the hospital association and its trustees, challenging among other things the validity of the method by which the two trustees were chosen. It is unnecessary to go into the details of the case, it being sufficient to say that where the stipulation entered into, provided that "all trustees shall be persons of good moral character," the supreme court of Kansas, November 4, 1922, held that the possession of a good moral character becomes

an essential qualification to hold office. It was held that one of the trustees who had recently committed embezzlement "is not eligible thereto, unless upon a showing of reformation, and his ineligibility is not affected by the fact of his having received a plurality of votes at the election."—*Hempstead vs. Atchison, Topeka and Santa Fe Hospital Association.*

THE SEASIDE HOME, NEW JERSEY

The property of the Seaside Home, owned and used by a corporation of New Jersey for charitable purposes, was held by the supreme court of the state, November 8, 1922, to be exempt from taxation, although not in actual use on the date of the assessment.

The question was: "Was the home actually used within the meaning of the statute, as a home, at the date of the assessment? The property was used exclusively as a summer home for eighteen or twenty years. It is solely adapted for summer use. The particular purpose and use of the property is a summer home for children and old persons supported by charity. There is no question raised as to the charitable purpose of the home."

The taxing statute under which exemption was claimed states: "All buildings actually and exclusively used . . . for religious, charitable or hospitable purposes. . . ." The state board, it seems, held that the words "actually used" means in actual use on the day of the assessment. This interpretation the court declares too rigid, ignoring the spirit and purpose of the statute. "The test of exemption cannot be made to turn upon the fact of an accidental closing of the home depending upon the weather, sometimes earlier, sometimes later in the season." On the other hand the court distinguishes this case from certain others in which property "intended to be used for a charitable purpose," but which had never been used for such purpose, and was not in use on the date of assessment, was taxed. "Intention to use property cannot be made the test of exemption from taxation, under the statute."—*Seaside Home vs. State Board of Taxes, 118 At. 705.*

HOSPITAL SERVES LARGE TERRITORY

The recent dedication of the new Lakeside Hospital at Rice Lake, Wis., attracted persons from points throughout all northern Wisconsin, it is said. The new building with its equipment cost \$175,000 and it claims the distinction of being the only modern hospital in an area of 100 square miles. The hospital overlooks the lake and has five acres for lawns, orchards and gardens surrounding it. The present capacity of the institution is sixty beds, but it has been constructed with a view to adding two additional stories when they become necessary. Miss Eva C. Greisen is superintendent of the hospital. Six students are enrolled for training in the school which will soon be opened in connection with the hospital.

HOSPITAL IN CONFLAGRATION

St. Mary's Hospital; at Astoria, Ore., was damaged by the conflagration which swept the business section of the city on December 8th. The patients of the institution were early removed to the high school building for purposes of safety. Although the fire later reached the vicinity of the hospital, it was untouched, except for the destruction of the windows by dynamiting and explosions of gasoline tanks. This building alone of all the important buildings in the business district, escaped destruction. The hospital contains 125 beds and is conducted by the Sisters of Providence.

NEIGHBORHOOD HOUSE DISPENSARY

A neighborhood dispensary has been approved for Auburn, N.Y., by the State Board of Charities. The corporation is formed under the auspices of the Women's Educational and Industrial Union for providing dispensary care for residents of the city unable to pay for medical treatment.

HOSPITAL RECEIVES BEQUEST

The Supreme Court of Illinois, in refusing a rehearing of the case concerning the will of the late Charles E. Haines of St. Charles, has brought to a close the fight for possession of a \$600,000 estate brought by relatives of the deceased. Mercy Hospital, Chicago, which under the will was given two-thirds of the estate, will now receive its share.

NEW HOME FOR NURSES

St. Joseph's Hospital, Lancaster, Pa., has purchased a large apartment house which will be converted very shortly into a nurses' home. The building is located directly opposite the hospital, three stories high, and contains sufficient space for 150 nurses. The purchase of the home has been made necessary by the recent enlargement of the hospital, which will eventually double the number of patients cared for. The new nurses' home contains at present 63 rooms and 18 baths, exclusive of the janitors' quarters. Extensive remodelling will be undertaken.

HOSPITAL DONATIONS

St. Mary's Hospital at Minneapolis, Minn., has received an endowment of a free bed in memory of the two sons of Mrs. Elizabeth Gilroy. Mt. Carmel Hospital, at Columbus, O., has received a gift of a marble statue in memory of Sister Brendon, former superior of the institution, from members of the hospital staff.

ORGANIZE ADVISORY BOARD

An advisory board for Hotel Dieu Hospital, Chatham, N.B., was organized on October 16th. The members of the board are as follows: Honorary President, Bishop Chiasson; Honorary Vice-President, Mgr. M. A. O'Keefe; President, W. Cassidy; Vice-President, Geo. McDade; Secretary, Howard McKendy. The remaining members are W. N. Walsh, C. P. Hickey, J. L. Martin, Dr. Losier.

The Surgeon General at Washington, D.C., has announced the opening of a new surgical hospital, to be known as Surgical Hospital No. 16, at Houston, Tex.

By the will of Mrs. Hannah Duryea the St. Louis University at St. Louis, Mo., has been bequeathed securities valued at more than \$50,000 to be used for dispensary purposes in connection with the medical school.

Book Reviews

Essentials of Surgery. A Textbook of Surgery for Student and Graduate Nurses and for those interested in the care of the sick, by Archibald Leete McDonald, M.D., The Johns Hopkins University. With 49 illustrations. Second edition, revised. The J. B. Lippincott Company, 201 Unity Bldg., Montreal, Quebec. Price \$2.50.

This book covers the general principles of surgical diseases and the pathological changes which result. The more important surgical lesions involving special regions of the body are considered. Discussion is made of causes, local tissue changes and effects. The natural course of the disease is presented and of spontaneous attempts to control the condition as well as factors in prognosis; then full indications for treatment and general principles of same. This new edition eliminates descriptions of technique. A new chapter is added on operative gynecology.

A Text-Book of Obstetrical Nursing. By Alice Weld Tallant, A.B., M.D., Professor of Obstetrics, Woman's Medical College of Pennsylvania, etc. Illustrated with 116 engravings. Lea & Febiger, Philadelphia and New York. Price \$2.25. 1922.

Of the several books on obstetrical nursing which have appeared in the last few years, this is the shortest and most concise. It covers the subject adequately from the nurse's standpoint, and there is no unnecessary padding. As the

author points out with emphasis, if there is any time in a nurse's career when she should give scrupulous attention to establishing and maintaining asepsis, it is during labor, for the patient's life may, and often does, depend upon it. Further, the sympathetic insight, which should constantly underlie the work of the professional nurse, will be needed at the crucial time of labor, in its finest sense. We are glad to see the human side of obstetrical nursing stressed as in this book.

Nutrition of Mother and Child, by C. Ulysses Moore, M.D., M.Sc. (Ped.) Instructor in Diseases of Children, University of Oregon Medical School. Including menus and recipes by Myrtle Josephine Ferguson, B.S., B.S. in H. Ee., Professor of Nutrition, Iowa State College, Ames, Ia. With 33 illustrations. The J. B. Lippincott Company, 201 Unity Bldg., Montreal, Quebec, 1923. Price \$2.00.

One-fifth of all deaths occur during the first year of life, and more than half of these are directly due to nutritional disturbances. Many mothers who realize the necessity of a well balanced and properly regulated diet do not comprehend what constitutes such a diet. This is not surprising when we consider the rapid progress recently made in nutritional knowledge. A study of good factors and the metabolic requirements of the human body is here presented, beginning with the old established facts of nutrition and co-ordinating with them the newer discoveries of recent years. This small book can be wholeheartedly recommended to all who are, or ought to be, interested in the welfare of mothers and children. The ideas presented are not such as advanced by faddists, but are facts accepted by schools of accredited standing. Emphasis has been placed upon breast feeding, vitamins and the mineral content of the diet. The sick child has been only casually considered, the purpose of this book being to teach mothers how to render their families less subject to disease. The book has also been so arranged that it may be employed by nurses and social workers for instruction of mothers in the home. Altogether a commendable little volume.

Transactions of the American Hospital Association. Twenty-fourth Annual Conference held at Atlantic City, New Jersey. Vol. XXIV, 1922. Published by the Association, Chicago, Illinois.

Those of our readers who are not members of the American Hospital Association will find some very up-to-date reports and addresses on administration, construction, dietetics, social service, dispensary work, book-keeping and other hospital topics. A perusal will be found well worth while.

Text Book of Anatomy and Physiology for Training Schools and other Educational Institutions, by Elizabeth R. Bundy, M.D. Fifth edition, revised and enlarged by Martha Tracey, M.D., Dr. P. H., and Grace Watson, R.N. With a glossary and 266 illustrations, 46 of which are printed in colors. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia. Price \$2.50 net.

The object in writing this book was to sort out of the mountains of anatomical and physiological facts, the few with which nurses ought to be familiarized. This has been satisfactorily done—briefly and clearly. The characteristics which have a practical application are emphasized. The chapter on digestion has been revised to accord with the newer knowledge in nutritional physiology. More is given on ductless glands, and the reproductive systems.

Principles and Practice of Infant Feeding, by Julius H. Hess, M.D., Professor and Head of the Department of Pediatrics, University of Illinois College of Medicine. Illustrated, third revised and enlarged edition. Philadelphia, F. A. Davis Company, publishers. 1922. Price \$4.00 net.

No one is better known than Hess. His work in pediatrics is outstanding. The work is designed for teachers and students for clinical conferences. Much of the subject discussed is illustrated by clinical cases and case-records. After dealing with the anatomy, physiology in the alimentary canal of infants and the subject of metabolism, he describes the bacterial invasion. Under "nursing," he discusses the natural, wet, weaning disturbances in the breast-fed and the methods of feeding prematures.

Dr. Hess tells of recent advances in artificial feeding and describes the adaptations of cow's milk, carbohydrate additions, the cream and skimmed milk mixtures, and outlines the dietary in late infancy and early childhood.

The next section of the book is given to a discussion of nutritional disturbances on artificially-fed infants. Chapters follow on rickets, scurvy, acidosis, spasmophilia and the anemias of infancy. There are numerous, fine pictures and a score of tables for the edification of the practitioner.

Physics and Chemistry for Nurses, by A. R. Bliss, Jr., A.M., Ph.D., M.D., and A. H. Olive, A.M., Ph.Ch., Ph.D. With 70 illustrations. Third edition, thoroughly revised and rewritten and conforming to the requirements of the Standard Curriculum (1922) of the National League of Nursing Education. The J. B. Lippincott Co., 201 Unity Bldg., Montreal. Price \$2.50.

I consider this text book too technical and too elaborate, as the great majority of pupil nurses in any training school have had little or no chemistry before entering. It does not seem possible to cover as much work as is here assigned in each chapter, to a class period.

Nursing in the Acute Infectious Fevers, by George P. Paul, M.D., C.P.H. (Harvard.) Director of the Department of Hygiene and Industrial Health, Antioch College, Yellow Springs, O. Fourth edition, thoroughly revised. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. Price \$1.75 net. 1923.

A practical volume for nurses. Great stress is laid on the subject of Care and Management of each disease. The book deals not only with the general aspects of fever, but discusses causes, symptoms, course, prognosis and management of all the acute infections. The later part of the work treats of procedures and information necessary in the management of the above diseases; subjects are clearly and concisely discussed.

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Rest and Other Things. A little book of plain talks on tuberculosis problems. By Allen K. Krause. Baltimore: Williams & Wilkins Company. 1923. Price, \$1.50 in the United States, Canada, Mexico, Cuba; \$1.60 in other countries.

Those who, because of wide public health interest, as clinicians, or individual interest as laymen, seek for a better understanding of their patients' problems, or of their own troubles, will find in this little book just the message which many have sought to put into words. The papers are sympathetic. The style is charming and fascinating. The author establishes an analysis upon a pure basis of fact, but in a fabric which is as alluring as the finest fiction. Filled with truths which may prove so vital to everyone and to every public health undertaking, Dr. Krause shares his experience in the tuberculosis field, and his treasure of information. "Rest and Other Things" will be of interest to the physician, the nurse, the public health and social service worker, the patient and the layman interested in tuberculosis.

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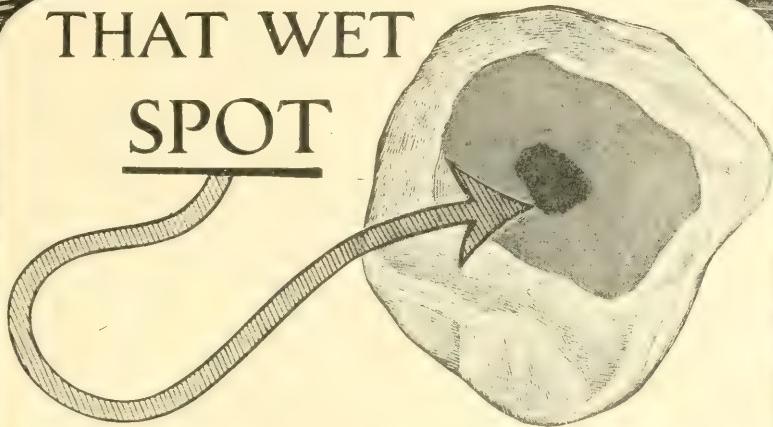
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HISTORY OF EXPERIMENTAL SCARLET FEVER IN MAN

Ludvig Hektoen, Chicago (*Journal A.M.A.*, Jan. 13, 1923) presents a brief review of the recorded attempts to produce scarlet fever experimentally in man, which reveals that it is exceedingly doubtful whether a single positive result has been obtained. In view of the ease with which scarlet fever appears to be transmitted under natural conditions and the not infrequent occurrence of surgical scarlet fever, Hektoen says the failure of the efforts at experimental transmission is a perplexing problem that awaits solution.

SPASMODIC FORCED RESPIRATION AS SEQUEL OF EPIDEMIC ENCEPHALITIS

The case cited by Irving H. Pardee, New York (*Journal A.M.A.*, Jan 20, 1923), presents a typical, but definite history of an acute epidemic encephalitis, with acute onset and some lethargy, followed by inverted sleep mechanism, thalamic involvement, as seen in the facies, retarded physical activity (movement), and evidence of autonomic disturbance in the period of excessive perspiration and the paroxysms of forced respiration.

OTITIC ABSCESS OF THE CEREBELLUM

The case reported by C. F. Yerger, Chicago (*Journal A.M.A.* Jan. 27, 1923), is of especial interest, (1) because of the difficulties it shows in diagnosis (some cases will give few, if any, localizing signs); (2) because a cerebellar abscess was found on surgical exploration of the posterior cranial fossa, and (3) because the necropsy report was added to the clinical record, thereby making the case record complete.

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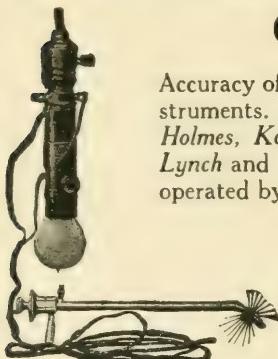
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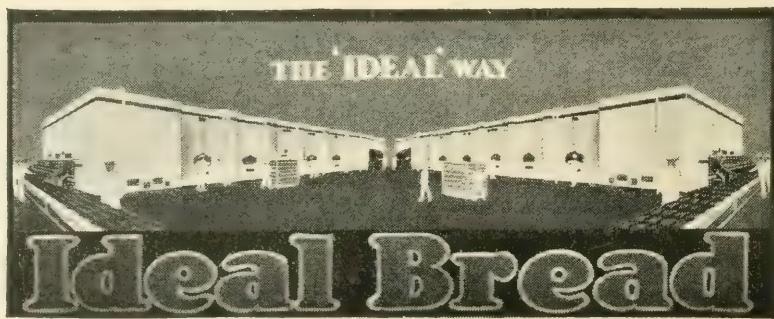
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Vol. XXIV

Toronto, July, 1923

No. 1

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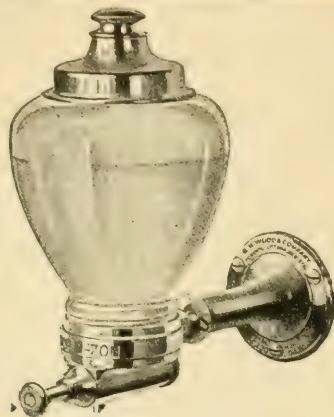
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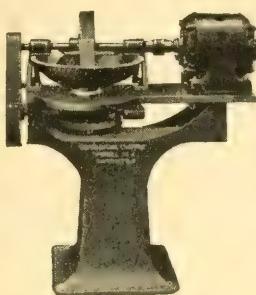
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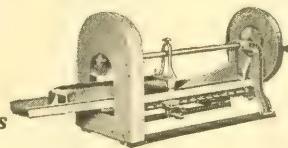
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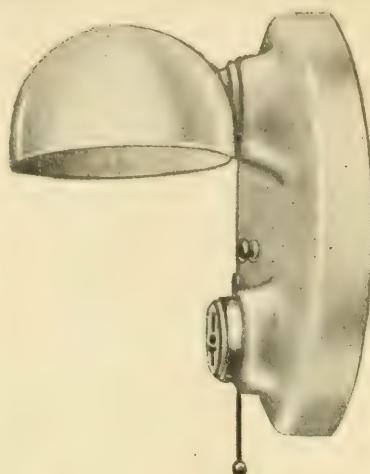
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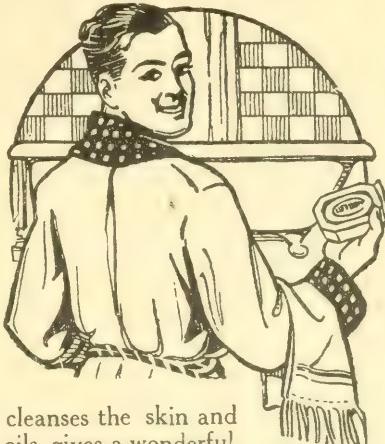
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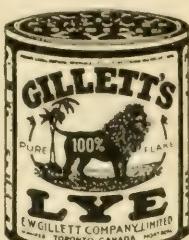
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The Hospital World

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Vol. XXIV

TORONTO, JULY, 1923

No. 1

Editorial

Growth of Nursing

Training schools (says the *Boston Manuscript*) are beginning to celebrate their 50th anniversaries. In 1880 there were fifteen training schools in the United States; ten years later thirty-five. The first conference of graduate nurses was held in 1893 at the Chicago World's Fair. The American Society of Superintendents of Training Schools for Nurses (a big mouthful of words) was here organized. At this time, however, there was an alumnae association of the nurses of Bellevue Hospital, New York. (It may be interesting to know that the veteran, Miss M. A. Snively, of Toronto, is an alumna of Bellevue).

Other alumnae associations were formed, and in 1897 the Associated Alumnae of the United States and Canada was formed—the first national organization of nurses doing all types of work.

Reviewing the growth of nursing organizations, in the *Health Journal of the Massachusetts Tuberculosis League*, Carrie Hall, R. N., says:

"From 1890 till 1900 training schools multiplied rapidly to meet the needs of the hospitals, and as usual in such development, they were without standards, and with courses more and more diversified. It was evident that something must be done to safeguard both the public and the nurse in matters of time and money.

"Under the principles of States rights it was necessary to secure the passage of a registration law in each State, for the reason that the general Government has no jurisdiction in such a matter. Physicians must get a separate registration for each State in which they wish to practise and the same is true of nurses. An R. N. from Massachusetts may have no value at all in another State. In order to secure registration laws in the different States the nurses in the States began forming State associations and as early as 1901 such an association was formed in New York, and the law secured the following year. Massachusetts had its nurses' association in 1903, but could not move the legislature to enact its law until 1910.

"There were now a considerable number of State organizations and naturally these wished to participate in national affairs, and did this by joining the Associated Alumnae. The name of the latter became a misnomer so that in 1912 steps

were taken to reorganize and it became the American Nurses' Association, and later membership was fixed to be through membership in a State association. This is to-day the great national body of nurses.

"In the meantime the Superintendent's Society had kept on with its work in educational methods, and in 1912 was reorganized and became the National League of Nursing Education, having eligible to membership all those participating in the education of the nurse. It had established a standard curriculum and was instrumental in the organization of the department of nursing and health at the Teachers' College of Columbia University.

"The youngest of the country-wide associations is the National Organization for Public Health Nursing, its membership being chiefly of those employed in public health, accepting members who are not nurses if connected with visiting or other nurse societies.

"Three national associations, educators of nurses, nurses themselves and public health nurses and their related officials exist in the country, two of them with State associations that are federated in them, and the third, the N. O. P. H. N., being at the present moment engaged in establishing State associations of public health nurses. The three national organizations have headquarters at 370 Seventh Avenue, New York City, where they are

in contact with one another and with the other national health agencies that have there been brought together by the National Health Council."

An Old Hospital

An interesting sketch of the Boston Dispensary which claims to be the third oldest in America, appeared in the recent issue of the *Boston Transcript*.

The institution, which had its beginnings in 1796, under modest and primitive conditions, has kept pace with modern medical progress. It is only within recent years that hospital record-keeping has reached an efficient stage, but the early records of the Dispensary are sufficient to show many interesting facts connected with early days and ways, and make very good reading.

The Dispensary began with one doctor; it has now one hundred and seventy-five, with a large force of assistants as social workers and nurses. The records of the Board of Managers show some of the best-known names in New England history, while the physicians have been of equally well-known families, who have served the institution from generation to generation.

An interesting treasure in the archives is a letter of application from Oliver Wendell Holmes, which reads as follows:

To the Secretary of the Boston Dispensary.

Sir—As a vacancy has occurred in the medical department of the Dispensary, I request to be considered a candidate for the vacant office. For recommendations, I refer you to three letters from Drs. Warren, Bigelow and Hayward.

Yours respectfully,

O. W. HOLMES.

The application was received on Jan. 13, 1837.

Dr. John C. Warren, who is referred to by Dr. Holmes, says of the latter: "I would with confidence recommend him as possessed of that practical skill, as well as amiableness of character, which are required in the office of dispensary physician."

The Dr. Bigelow mentioned was Dr. Jacob Bigelow.

The letter brings the golden-humored author in close touch with the profession he honored.

Dispensary administrators had their vicissitudes with patients of a century ago as they have to-day.

The Dispensary in the early days had a "vintner," whose duty it was to dispense wine, just as the apothecary dispensed medicines. But in 1806 the managers felt constrained to issue this order: "The quantity of wine allowed in future to patients . . . shall not exceed two quarts during the whole of their sickness, and that to be sherry only." There is a tradition also that a mixture of cod-liver oil and whiskey, prescribed for certain patients, was discontinued because the patients were in the habit of allowing the oil and whiskey to separate and then drinking the whiskey through a straw.

The sign of the Boston Dispensary from earliest days has been the Good Samaritan, and this sign—a quaint device originally costing seven dollars—has been retained down to the present. To-day the Dispensary is a large and up-to-date hospital with all modern departments.

Officious Nurses

The old family physician has sometimes difficulty in keeping pace with certain of the modernly-trained nurses, when occasionally they are inflicted upon him. An instance: One of our seniors in the profession was recently called to see a twelve-year-old girl whom he had attended successfully for several years past. She was suffering from a bad throat non-diphtheritic—probably a streptococcic infection. A nurse, trained in a certain children's hospital, was called in by the mother of the child. Following a severe two weeks' acute sickness, the child's convalescence set in. The physician had almost ceased his visits, when one day he was called up by the patient's father to say that the girl was anemic and not convalescing as rapidly as they thought she ought and they wished a children's specialist brought in. To this, of course, the family physician agreed and with a probably equal alacrity the children's specialist, trained in the same hospital as the nurse, took on the case to put in the finishing touches.

The family physician hereafter will be loath to employ or work with nurses of this sort; and wonders what sort of ethical training is given in this super-hospital.

In Dire Straits

The writer of this article is in receipt of the following communication from the Honorary Secretary of the Jervis Street Hospital (established 1718), Dublin, Ireland:

March, 1923

Dear Sir:

The Dublin Sweep has been organized to enable this institution, which is wholly dependent on voluntary contributions, to carry on its good work.

We take the liberty of enclosing a book of twelve tickets, and trust that if unable to dispose of them personally you will hand them to one of your friends who may be in a position to do so.

We are making a special appeal to all professional men in the knowledge of the generous contributions made by them in the past to the cause of charity.

The seller of this book is entitled to take two complimentary tickets, forwarding counterfoils with remittance of ten dollars to us.

Faithfully yours,

P. J. COONEY,
Hon. Secretary.

The recipient of the book has "passed the buck" to a confrère who, though very fond of horses, will also pass it.

It seems unfortunate that any hospital board has to resort to this questionable and uncertain method of raising funds.

The day is passing when the few will consent to give money voluntarily to care for the many. The self-respecting poor do not propose much longer to pauperize themselves by accepting charity. More and more in the old land we note the voluntary principle losing ground in respect to hospital support. Appeals are being made for State aid and charges for maintenance are now beginning to be made in some of the oldest and most conservative hospitals.

Practical Nurses

In the Missouri legislature was recently passed a bill, providing that registered nurses should have one year of high school preliminary education and two years of hospital training. The bill gives practical nurses recognition by allowing them to use the title "Practical Nurse," or "P. N."

This action is in line with the movement for the classification of nurses. Broadly speaking, we think the time will come when there will be three classes of nurses: the highly trained, specialized nurse, who will have a special title, the fully trained graduate nurse, and the so-called practical nurse.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

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Editors:

ALEXANDER MacKAY, M.D., Inspector of Hospitals, Province of Ontario.

JOHN N. E. BROWN, M.B. (Tor.), Ex-Sec'y American and Canadian Hospital Associations, Former Supt. Toronto General and Detroit General Hospitals.

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JOHN N. E. BROWN, M.D., FORMERLY SUPERINTENDENT OF
THE HENRY FORD HOSPITAL, DETROIT, AND OF THE
TORONTO GENERAL HOSPITAL.

Fifty years ago there were 140 hospitals in America; today there are over 7,000. In those days patients dreaded to enter a hospital on account of the frightful mortality resulting from sepsis—erysipelas, gangrene and other deadly infections. Now, thanks to the introduction of the principles of antisepsis, asepsis, trained nurses and improved operating-room technique, hospitals are eagerly sought by people of all classes.

HOSPITAL SUPPORT¹

Civil hospitals, generally speaking, are supported by voluntary contributions from charitably disposed persons, by state or municipality funds (or both) and from charges made to patients. There is a distinct trend toward supporting public hospitals, other than sectarian, by general taxation, as exemplified by many hospitals in the cities of the United States. The Canadian provinces of Alberta and Saskatchewan have enacted legislation which provides for hospital support in this way. In Great Britain the voluntary principle has, until recently, prevailed (except in respect to the Poor Law Infirmarys) but many of these hospitals are now beginning to charge patients and are making an effort to secure assistance from the public exchequer. On the Continent, the majority of hospitals are maintained by public tax. (Study the last yearly report issued by your hospital to determine the source of the hospital's funds and the way in which these are budgeted).

HOSPITAL SITES

As to the best site for a hospital, there is a decided division of opinion among those who have given thought to the question. On the Continent the pavilion type is seen most often. This consists of many buildings of one, two, or even three stories spread over many acres of land beautifully parked. This type flourished as the result of wars, being modelled after the military hospitals. As a result of the discovery of bacteria and infection, it was found to be an advantage to segregate, in these separate units, patients suffering from various sorts of diseases, thus minimizing the danger from cross infection.

In American cities, the multi-storied single building seems to be preferred. This brings the administrative, medical, nursing and domestic services into a closer relationship and makes for the economizing of time and money. These institutions are, as a rule, centrally located. The first type on the other hand are situated in the suburbs, removed from the noise, bustle, dust and smoke of the city, in open spaces covered with flowers, grass and trees, with access to plenty of sunlight, fresh air and quietude. From the standpoint of the patient there should be no difference of opinion as to which is the better place for him to seek for recovery.

CONSTRUCTION MATERIALS

More and more it is becoming the custom to build hospitals of fire-proof material, ferro-concrete being largely used. Care is taken in planning to see that there is room for expansion and growth. A certain amount of flexibility is desirable since changes in interior arrangement are often made as the needs increase and knowledge advances. In some of the newer hospitals solid plaster partitions, such as gypsite, are supplanting hollow tile. These are more easily torn down in case it is decided to enlarge wards or service rooms.

INTERIOR FEATURES

In the newer hospitals care has been taken to avoid angles, ledges or projections of trim from the walls, as these favor the accumulation of dirt and dust. Baseboards, wainscots, door-jambs, window frames are built flush with the walls and

doors made perfectly plain. Movable furniture is being replaced by built-in cabinets for the same reason. In these may be kept dressings, blankets, solutions, instruments, utensils, medicines, fire hose and the like. Angles at floors and ceilings and between walls are covered to facilitate cleaning. Large window-panes are also desirable. Fire stairways should be built inside, being a part of the construction. The outside iron fire escape is out of date.

Floors of the hard type—terrazzo, or tile—are desirable for service rooms, kitchens, laundries, sink rooms, laboratories and the like; floors of the soft type—composition flooring, rubber or battle-ship linoleum are more suitable for wards. Hard-wood floors still find favor with some authorities, particularly in private wards. When well polished and covered with suitable rugs, these give a home-like touch, which patients value.

Public wards are considerably smaller than formerly. In several of the newest hospitals in the United States, separate rooms are provided for each patient. Large wards should run north and south, thus receiving both morning and afternoon sunlight through their side windows. Windows should be double-hung to permit of the freest possible ventilation and ease of cleaning. Supplemental ventilation may be supplied through outside transoms. Inside transoms are being omitted in the newer constructions. Vitiated air from kitchens, service rooms, laundry and laboratories may be withdrawn by means of an exhaust fan.

HEATING

For hospital purposes the heating system should be separate from the ventilating. In very few hospitals have they been found to work well combined. Most of the mechanical systems in America have fallen into disuse. The favorite system of heating is by means of hot water. Certain hospitals are trying out oil as fuel. Small wards should be provided where nephritis and diabetes may be kept particularly warm. Rooms for pneumonia and all tuberculous affections should be provided with cool, fresh air, while patients with certain bronchial and laryngeal affection should be placed in rooms in which the air is moist.

OUT-OF-DOOR TREATMENT.

Generous provision is required for treating convalescents and bed-patients with anemia, tuberculosis, pneumonia and the like in the out-of-doors. This is best secured by building fire-proof verandahs off the wards. One of the big New York hospitals has as much out-door room as in-door. A visitor will see as many patients on the verandah of a ward as he will see in the ward. The balconies should be ten or twelve feet in width to allow for the movement of beds and give working space to nurses. Portions should be made closable to protect patients who are out all the time, from inclement weather.

PLUMBING

Many hospitals fall short on plumbing fixtures. The Riggs Hospital, Copenhagen, has lavatory basins right in the interior of the ward. This enables doctors, nurses and attendants very easily to wash their hands after attendance on each patient, thus minimizing the danger of cross infection and at the same time protecting themselves. (The private wing of Mt. Sinai Hospital, New York, and the rooms in the New Fifth Avenue Hospital, New York, contain complete plumbing fixtures and the implements needed in medical and nursing procedures). The methods of the operating room may well be copied in the medical wards. Local provision should be made for the sterilization of instruments and utensils. As a rule, more baths, closets and lavatories are needed for patients, nurses and personnel, not forgetting provision for visitors. An occasional new hospital has a toilet set connected with each private ward, in imitation of many of the newer hotels.

BASEMENTS

As time goes on dark basements are being utilized for heating apparatus, pipage and storage only. No hospital doctor, nurse or employee should be compelled to do his day's work underground. There is plenty of room on top; it is not difficult to make space above ground for all hospital services, if a little study is given to the planning. A few weeks ago a clerk who worked in the basement of one of the Toronto city institutions was sent to a tuberculosis sanitarium. Those

who planned to put the X-ray department in which she worked in the basement did not foresee this tragedy.

PROVISION FOR SPECIAL CASES

Provision should be made for the care of incipient mental cases, patients in temporary delirium or other psychoses. If the hospital constituency is large enough special rooms, wards or pavilions should be constructed for them.

The obstetrical department should be well walled off from other parts of the hospital. All but the smallest special hospitals should take care of children. In short, a general hospital should refuse no type of patient. With this in view, the great British hospital expert, the late Sir Henry Burdett, prophesied the coming of the hospital city. We dare say he had this dream after visiting such wonderful hospitals as the Virchow in Berlin, and the Eppendorf in Hamburg. In these hospitals every possible type of illness is looked after. What an advantage to the patients, not to speak of the great benefit that such diversified experience offers to medical students and nurses! In these large continental institutions, one even sees special buildings for typhus and plague².

A suite of rooms should be provided in all general hospitals for the accommodation of cases of infection, such as diphtheria, scarlet fever, and the like, which some time break out. Many of the newer American institutions have special receiving departments in which all public ward patients are held for a few days to make sure that they have not brought in any infections with them.

LABORATORIES

Nowadays much thought is given to laboratories. Those for chemical, bacteriological, serological and research work may be grouped. If they are placed centrally, it is a great convenience to clinicians. These should be supplied with all the necessary apparatus. The rooms should be light, airy and sanitary.

In the larger hospitals, provision is made for carrying on a certain amount of routine work in the small laboratories connected with each service. Where teaching is done, these laboratories form a prominent feature of each division.

OUT-PATIENT SERVICE.

Many hospitals suffer from insufficient space in which to carry on satisfactory out-patient work. Waiting rooms for patients should be spacious, light and well ventilated. The various services, medical, pediatric, orthopedic, surgical and others should be conveniently grouped around the general waiting room especially for initial visits. Subsequently it is often desirable to prevent cross infections and promote speed to provide separate entrances. Records, however, should be centrally kept and managed to maintain an inter-knowledge of departments. Separate dressing and examining rooms are desirable as well as lavatory and toilet accommodations. Office space should also be planned for social service workers. Some of the old country hospitals serve a light refreshment to any patients desiring it. It is recommended that the oldest and best clinicians serve this class of the public as it is here the beginnings of disease are to be noted, which are often overlooked by the tyro.

EQUIPMENT

Dumb waiters are being thrown into the discard in many quarters. Their place is being taken by service elevators ample enough to carry beds, warmed food, carriages and supplies of all sorts from one floor to another. In the Fifth Avenue Hospital, which maintains a central dressing station in the basement, "sterile" and "dirty" carriers are provided.

A laudable effort is being made to standardize certain sorts of equipment, such as plumbing fixtures, lighting fixtures, hardware, furniture, and the like. If this could be thoroughly effected, it would make for economy of time and money, and ease of administration.

NURSES' HOMES

In the ideal nurses' home, each nurse is provided with a separate room with running water in it. Special rooms are provided for demonstrations, lectures, libraries, recreation, study. Teaching rooms should be fully equipped with running water, gas, and the proper working materials. It should not be necessary to assemble the usual equipment for each class. Some go so far as to provide roof gardens and swimming pools.

Of great convenience is the petty laundry and petty kitchen. Special thought should be given to securing for nurses who work at night and sleep during the day, apartments that are beyond the reach of noise. A full-length mirror located in the lobby of each story was noted by the writer in a Boston nurses' home. At a glance, going or coming, the nurse was thus able to detect anything awry in her attire.

HOSPITAL STANDARDIZATION

Great credit is due to the American College of Surgeons and other medical and hospital organizations for their interest in standardization. The regular staff meetings for the review of cases have done much for the patients, the staff, and the nurses. These conferences have resulted in fuller, better kept, safer and more easily available records. Also arising from the staff meetings have come the introduction of adequate laboratories, and competent laboratory workers and instructors who have been of untold help to the clinical workers. These efforts toward standardization have served to strengthen clinical methods of teaching, which in turn have provided greater opportunities for study on the part of nurses.

Consultations are becoming more frequent; autopsies are being more often performed, and in every hospital which has seriously taken up the work of standardization, there has been created a better *esprit de corps*. Although the idea has been effective only over a very recent period, one notices greater care in the study of cases and surer diagnoses. Surgeons are more cautious, more careful in their technique, with the result that there are fewer complications and unhappy endings. Internal medicine specialists are pointing and perfecting their work with greater accuracy. Father Moulinier says that during the past three years in Catholic hospitals alone, some thirty to forty thousand unnecessary operations have been prevented, fifteen to twenty-five thousand incompetent operations spared patients, and an equal number of criminal operations barred.

COST ACCOUNTING

Every hospital should have an up-to-date accounting system, in order that the administrator, trustee board and anyone interested may secure a monthly and annual statement on

a revenue-expense basis. To know at the end of each month how much per day, per patient, each main item in the hospital expense category is costing in the medical, surgical, obstetrical, nursing and domestic departments, affords the superintendent much satisfaction. Such knowledge enables him or her to put a hand on the leak or on the head of the department who is extravagant in the use of any of the supplies.

STAFF APPOINTMENTS

Whether hospitals are open or closed the military system of appointment is to be commended. One man, and one only, should be held responsible for the work of each of the chief services—medical, surgical, obstetrical, laboratory, etc. These chiefs, with the superintendent, may well form a medical advisory board to whom the trustees may refer all general medical matters, and from whom the trustees may receive recommendations as to requirements of the staff. Such advisory boards may recommend associates, juniors and internes for appointment.

These points mark the milestones in hospital progress. As seniors with a back-ground of experience in all the departments of the hospital, you are now in a position to look upon it as a whole. Think back over the incidents of your educational training. Look at your hospital with new eyes.—The Nurse.

REFERENCE NOTES

¹As senior, nurses should have an appreciation of the problems of financing. This knowledge will help them to understand the natural conflict which arises between the interest of those serving the sick and those conducting a nursing school for students. Because gifts which are donated to care for patients cannot in honesty be diverted to the education of pupils, we sometimes find the anomaly of a beautifully equipped hospital which provides no facilities for the teaching of students and few teachers. Perhaps the hospital's finances are so tied up that the student's time which should be spent in study or the care of patients is utilized day after day for the cleaning of corridors, counting of linen, etc. The solution is a separate budget for hospital and training school.

The 1921 recommendation made by the American Hospital Association—that venereal and tuberculosis patients be cared for in general hospitals—demonstrates the newer attitude. If nurses, physicians and hospital attendants preserve perfect technique, the future holds many departures.



Selected Articles



THE PSEUDO-MEDICAL CULTS SOME PROBLEMS CONFRONTING THE MEDICAL PROFESSION

MALFORD W. THEWLIS, NEW YORK CITY

The question of the various new healing professions, which have sprung up during the past decade and thrive on treating disease without being properly equipped to cope with it, has brought before physicians a problem that is not easy to solve. Each of these bodies is conducting an organized campaign against the medical profession and asserts that physicians are unnecessary, the majority claiming that "spinal adjustment" will cure all ailments. They advertise boldly, the chiropractors even broadcasting radio messages, heralding their cures.

The physician is obliged to face the question because many of his patients are also subjects of these "paths," especially those belonging to the idle classes. Recently, a woman presented herself at a clinic for an X-ray examination. She said that she could not afford to pay for it and the social service began an investigation, finding that she really was unable to pay. She was X-rayed and a diagnosis of Pott's disease was made. She then explained to the physician why she could not pay for the X-ray. She had been to a chiropractor who had removed the "clicks" from her spine and, after having spent seven hundred dollars, she finally concluded that she was not better. Then she went to a regular physician. Like most of those patients who had been plundered by quacks, she was too ashamed to appear in court against the chiropractor. Had it been a physician who had maltreated her in any way, she would have lost no time in bringing legal action.

It is the duty of every physician to use his influence in order to overcome these meddlers with the sick. If every physician would take time to seriously explain to ten patients,

who are not subjects of these schools, why they are unsafe, approximately 1,500,000 people would be reached in this manner.

IRREGULARS HAVE PRODUCED NO SCIENTIFIC WORK.

In going back over the remarkable works performed by our profession, we always think of Jenner, Lister, Koch, Ehrlich, Metchnikoff, Widal, and others too numerous to mention, who have devoted their lives to science. We cannot but think of the sacrifices they have made to advance medicine. Can any Christian Scientist, osteopath, chiropractor, or "healer" of any kind name a single man who has done serious scientific work? The answer is obvious. Such men have nothing to offer except certain theories, which, they claim, will make possible the cure of all kinds of diseases. Have they any standards of education? Is a college degree (or any preliminary education) required before a student is allowed to enter such schools? Many of these very men who are preying upon the public were machinists or department-store clerks before they decided to get into a field which offered more inducements from a financial standpoint, besides giving them the title "doctor." This latter title is becoming like that in vogue in Kentucky, where anyone who has not committed murder is entitled to the name of "colonel."

The graduates of these schools have no knowledge of human anatomy or physiology, and their success depends upon having patients who have little knowledge of the human system. Everyone should know that the vertebrae cannot get out of place and that this mystifying "cracking and snapping" of the spine, which they dwell upon, can be produced by almost any human being. Read this advertisement of a chiropractor: "Chiropractic is the only science that adjusts the cause of diseases. When a chiropractor gives proper adjustments, he can obtain ninety-five per cent. good results. But, with two or three clicks on the spine and improper adjustments, satisfactory results cannot be expected."

This piece of printing is an insult to average intelligence. In the first place, how can the spine get out of adjustment? In the second place, what can a "click" be? Grammar-school pupils should be taught the elements of physiology more

thoroughly, so that they will not become victims of quacks in later life.

LOVE OF THE MYSTERIOUS AND UNUSUAL

Love of mystery prevails and there is no nation in the world where health is exploited for commercial purposes as much as it is in our own country. Coué takes America by storm; yet, I venture to say that, in five years, his name will be forgotten. A few idle women will no doubt enjoy him. The mysteries of the subconscious mind have become the mind-stuff of the "educated" to-day and are served up at dinners and teas. Couéism may be summed up in one slangy phrase "kidding yourself along." Undoubtedly, Coué has received several donations from those who might object to a fee of five dollars from a regular physician and probably keep the latter waiting a year for it.

One of the latest fads for health seekers among the idle classes is that of standing on one's head for several minutes in order to "change the circulation." Society women are very enthusiastic about this method. Some time ago, the fad was stretching by means of an apparatus which many had installed in their homes. As with most of these treatments, there is usually a substitute for mental or physical exercise.

The "natural bone-setter" has been another menace. In the state of Rhode Island, there was a family of bone-setters who, for years, made a great deal of money playing with fractures. The last of them could neither read nor write, knew nothing of anatomy, yet he had a large practice. He denounced X-rays. His "remarkable" results were investigated and subsequent X-rays proved that, in half of his cases, the bones were not broken at all. His method of procedure was to take a man who had a severe sprain of the ankle, for example, and announce that it was a bad fracture. He pulled on the joint and the patient suffered agony while he "set" the bone. Then he applied his bandage, removing it every three or four days for five weeks, applying "angle-worm ointment," finally permitting the patient to walk. Naturally, the result was good, owing to the fact that there was nothing but a sprain in the beginning.

THE CAUSE OF THE SITUATION.

While physicians are endeavoring to prevent these people from practising medicine, by framing laws against them, let us reflect a moment on the actual cause of the situation. The propaganda against the family doctor resulting in the alleged disappearance of our old friend who came to us in all circumstances, the wave of therapeutic nihilism, which has swept the profession, naturally created another kind of practitioner to replace him. "Medicine has changed in the past fifty years, but human nature has not" (Nascher). Why cannot patients be served better than they were fifty years ago with all the scientific advancements? Too many physicians have been preaching that drugs were of no value, that they could practise medicine with ten remedies, and expanding other theories which have taken confidence away from the medical profession. I find that many people actually dread to go to a physician and prefer to seek relief from other sources. Why does this dread exist? I am told that to see a physician often means passing from one specialist to another, with an ultimate expenditure of money that is beyond most patients' means, besides the inconvenience involved. Any physician who takes time to talk with his patients soon discovers this and, since the war, medical fees have become too high and the laboratory has added another expense to the patient.

The nihilism in therapeutics referred to above does not work out when physicians themselves are ill. A few years ago, in a military camp, several medical officers were discussing the fact that drugs were of no value; they had little confidence in them and were willing to treat pneumonia without medication. (Trousseau said the same thing, but added that he had never dared to try it). An epidemic of influenza came and several of these very physicians were ill and were sent to the hospital; every one of them complained that he was given no medicines and one actually cried when the mail did not bring a special prescription which he had ordered!

Place yourself in the position of a patient. Consult a physician who gives you no hope, who treats you as a disease and not as an individual, who tells you to go home and take a "rest cure" without medicines, and wonder if this thera-

peutic nihilism appeals to you. The average physician, upon graduation, has been taught that about one drug was necessary for all diseases; that was hexamethylenamine. What will become of our therapeutics now that this has been shown to be of little value?

PATIENTS WANT ENCOURAGEMENT

One of the first things a patient requires is: encouragement and hope. The average physician to-day is hypocritical. The patient wants medicine, which, he hopes, will relieve him. He will probably consult various physicians in the attempt at getting relief. He always finds the osteopath and chiropractor ready to promise him a cure. To a great extent, these various men are the direct result of our therapeutic nihilism. Most of the ailments now treated by them were formerly treated by the family physician, who was always ready to help. Perhaps he did not always treat his patients quite according to the latest methods, but he treated his sick people and benefited the sick souls.

Robert Bartholow said, in 1876, in an address before the medical and surgical faculty of Maryland: "He who despises his art, can never become a great artist. Good practitioners are always found to be men entertaining the greatest confidence in the powers of medicines." Jacobi wrote, in 1908: "Medicine is more than a pure science. It is a science in the service of mankind. We live in the era of therapy; therapy in politics, social and individual life."

Jacobi pleaded for years for therapeutic optimism. He died before the cycle of nihilism had run its course. But, optimism will come back. Modern medicine has practically taught us that drugs were of no value; yet, there are many valuable remedies which were used successfully by Rousseau, Watson, Clark, Flint, Ringer, Jacobi, Beverley Robinson, and many others, which remedies have never been heard of by the younger practitioners. In science, there should be no missing links, the works of our old masters should be combined with the present.

While the real surgeon has our entire confidence in his work, the "occasional" surgeon is usually a menace to hu-

manity. He mixes surgery with general practice, easily carrying streptococci from the infected throat to his surgical patient. Let surgery be done by surgeons who do nothing else. There is hardly any condition a patient consults an "occasional" surgeon for, which, in the latter's opinion, does not require surgical interference. It is the "occasional" surgeon who performs unnecessary operations, removing innocent appendices and preying upon wombs for tipplings and warpings. To him, a stomach-ache is always due to an "injected" appendix.

The fear of this "occasional" surgeon, the therapeutic nihilism of the physician, the increased cost of medical examinations, the fact of being forced to pass through the hands of several physicians before the diagnosis of a simple ailment is made, these are some of the things that induce patients to go to practitioners of the various cults, where the procedure is more simple, apparently less expensive and where some encouragement is always given. The more specialized medicine becomes, the greater will the practice of these "paths" become.

WHAT THE CULTS ACCOMPLISH.

We are told by some patients that they were cured of certain ailments by osteopaths and chiropractors, and actually some of them were relieved by these men. What do they do? A rich woman, for example, plentifully supplied with adipose tissue, finds herself suffering from "stomach trouble." Her diet is rather complicated, she loves and lives to eat, hates to exercise, she motors daily, but never walks; she has "auto-ititis." If a physician should advise her to walk every day, to take some setting-up exercises, she would improve rapidly; but she does not care to exert herself and goes to an osteopath. He manipulates her back, massages the woman and gives her a better circulation. Her neck is straightened, her chest thrown back, her abdomen in, and, all in all, she obtains, for five dollars, the result which could be hers if she would exercise herself.

These "paths" have been known to treat diphtheria without antitoxin, much to the regret of the family; they also manipulate spines which are affected with Pott's disease and

backaches due to cancer of the sigmoid. Recently, one "adjusted" the spine of a patient who was passing a kidney stone, but a physician was later called to administer morphine.

THE REMEDY

How shall this problem be solved? First, we should do everything in our power to have legislation enacted against the unqualified practitioners. Physicians are notoriously lax in medical polities. They do not realize the great harm that is being done to medicine by these unprincipled men who are commercializing medicine.

Physicians should increase their own efficiency, to enable them to do better work, thereby making the "paths" unnecessary. The work of Sir James Mackenzie, at St. Andrew's Institute, Fife, has shown that the family physician is in a peculiar position that enables him to be the most useful of all practitioners. He sees the patient at the beginning of his illness, he knows all of the family history and is better able to judge his condition than anyone. Let the physician who says that he can practise medicine without drugs pass on, for he is senile. Let the family doctor come back with renewed energy, equipped with post-graduate teachings in diagnosis, X-ray, blood examinations, laboratory tests, electrical diagnosis instruments and with scientific electric apparatus for treatment. Let him be so well educated that he knows his own limitations, and he will send patients to specialists because he knows why he is sending them. Men of this kind will increase their own practice and, at the same time, send more patients to specialists, since they know better how to handle these particular "cases."

There is a large field for the general practitioner who is able to do the right kind of work. The first examination of the patient by the efficient general practitioner will be thorough and include an examination of the whole body, an inventory, as it were, of every organ by means of physical examination, laboratory tests and X-ray. Let the fee always be within reason and give the patient no cause for criticism. Patients are always willing to pay well for services which are well and faithfully given, provided results are gained. The more efficient these examinations are, the less unnecessary

and the more necessary surgery; less ruthless extractions of teeth (this wholesale extraction of teeth upon physicians' advice, without relieving the diseased conditions, has turned a multitude of people against them); less groping from one group of doctors to another. If patients can get satisfactory results from their physicians, they will not seek outside help.

Therapeutics should be taught more and more and the works of the older physicians should not be overlooked. The writings of Rousseau and our great Jacobi are replete in therapeutic suggestions. Many modern books have been copied from Ringer's Therapeutics. French physicians have great faith in therapeutics and we find no unqualified practitioners in France. Perhaps it is because the French people are better educated in medical matters than our lay people. In France, the newspapers print only the proceedings of the Academy of Medicine, and the other academies, while in America we are always served with some freakish ideas, which have no foundations. We are told that the poison of the Gila monster (*Heloderma*) is a useful remedy for locomotor ataxia, or some other fraud of this kind.

Physiology should be taught to better advantage in our schools. It is pathetic to hear a seemingly educated woman say that she has a pain in her liver on the left side, to find that she does not have the slightest idea where the gall-bladder is.

In this day of highly-specialized medicine, physicians are the victims to a certain extent. In certain chiropractic schools, which teach every weapon against the medical profession, students are warned not to attack some of our medical associations. They say: "Let them alone; they are killing medicine themselves."

Are we killing medicine?

—(*American Journal of Clinical Medicine.*)

A HOSPITAL "MAINTENANCE" SYSTEM

Sir George Beatson, consulting surgeon to the Glasgow Western Infirmary, has recently issued in a pamphlet a notice of a financial reconstruction scheme for Scottish voluntary

hospitals. He has given the name "maintenance system" to the scheme he enunciates. Briefly, it may be said that he divides the cost of hospitals into two parts—the maintenance of the hospital itself, and the maintenance of the patients. He proposes that the expenditure on the hospitals shall still be met by the contributions of the charitable public, but that the patients should pay, either personally or through benefit societies, for their food, drugs, and dressings. The sum so to be provided by or for the patients he estimates would, in Scotland, average about £1 a week. The interest now felt in the financial position of hospitals is so widespread that any suggestion from a hospital worker of such long and varied experience as Sir George Beatson is sure to command attention. There are some points in his scheme which may be felt to need further explanation. He states that voluntary hospitals no longer confine themselves to the field of work for which they were established—the care of the necessitous sick poor—but are meeting the needs of other sections of the community, such as artisans and members of the lower middle class. Sir George Beatson points out that voluntary hospitals have now to meet a much higher expenditure, especially on the surgical side, than in the past. What, then, it may be asked, is exactly meant by the term "necessitous poor?" The ordinary primary meaning of "necessitous" given in the *New English Dictionary* is "placed or living in a condition of necessity or poverty; having little or nothing to support oneself by; poor, needy; hard up." But this, in the circumstances, does not help us very much. Does ability to pay £1 a week under an insurance scheme requiring the payment of a few pence a week remove the individual from the ranks of the necessitous poor? Or, taking the other extreme, does inability to afford the cost of a surgical operation and a nursing home bring the patient within the class? Again, is a person legally a pauper to be included in the necessitous class? Sir George Beatson agrees that an "income limit" must be enforced by a voluntary hospital, but it is admittedly not easy to fix the measure of this limit. We understand Sir George Beatson to include in the maintenance of the hospital itself, besides buildings and rent and taxes, the expenditure on salaries and the running expenses in drugs, dressings, etc., of the out-door

dispensary, as well as the cost of management. We gather that he would assign to the patient's side of the account the cost of wear and tear of equipment for serving food, and the surgical dressings. It will, we suspect, be difficult to make a sharp distinction between the two headings of expenditure for maintenance of hospitals and expenditure on maintenance of patients. Sir George Beatson's scheme must be considered in its relation to the present hospital policy of the British Medical Association. He says that a "definite advantage of the maintenance system is that under it there will be no grounds for medical men claiming remuneration for the services they render, because the hospitals will be receiving no payment for treatment." The Association proposes that in the event of patients paying in part or in whole the hospital maintenance fees, either individually or by some contributory method, or with the addition of rate or State aid, or a combination of any two or more of these methods, a percentage of all such payments should be passed into the staff fund. At the Annual Representative Meeting last year a resolution was adopted affirming that where such payments are in part made by rate aid or State aid, or in other cases are of an amount exceeding the cost of hospital maintenance and accommodation, such charges should be considered to include payment towards maintenance and treatment, and a percentage of all such payments should be passed into a fund to be at the disposal of the honorary medical staff. Sir George Beatson's views are ingenious and stimulating, and therefore worthy of study.—(*Exchange*).

WHAT SOME HOSPITALS ARE DOING

F. HOEFFER McMECHAN, A.M., M.D.

Certain activities, within the profession, and especially in the hospitals, have become prevalent recently, that are very destructive of the ethical standards of the practice of medicine, as well as demoralizing to the friendly relations that should be encouraged between patients and hospitals.

There is a tendency on the part of some hospitals to claim the patient as belonging to the hospital. The patient belongs

to himself and his near and dear ones, and is neither the property of the hospital nor the doctor. Certain hospitals would like to exercise this unwarranted proprietorship in order to commercially exploit the patient and the profession. The idea is to take possession of the patient at the front door, make a diagnosis by means of a flat-rate technical staff and then inform the patient what his hospital stay and treatment will cost him, collect the fees involved and pro-rate them among all concerned. This means a medical staff utterly dominated by the hospital management and serving at the mercy of the lay board of trustees.

The whole scheme involves commercial exploitation not only of the profession, nurses and specialists, but of patients as well. Nowhere is this better seen than in the relations of certain hospitals to anesthesia.

These hospitals, under the control of certain questionable leadership in hospital and medical associations, are using nursing anesthesia. To make this service pay a stupendous profit, these hospitals give their nurses a nominal salary for trying to give anesthetics, charge the patients the usual anesthesia fees for expert service, and turn the balance into the treasury of the hospital.

In order to make this plan work it is necessary to close the doors of these hospitals to medical and dental anesthetists, because nursing anesthesia cannot be made to pay in competition with professional anesthesia. In consequence we are advised on the best authority that five medical hospitals in Cleveland alone bar all members of the medical and dental professions from giving anesthetics in their operating rooms, not only in charity, but also in private cases.

The same situation of boycott and lockout obtains in the hospitals of other cities. This situation is bad enough from any viewpoint of ethics or decency. But there is another situation that is growing prevalent that is even worse. Some hospitals condescend to permit medical and dental anesthetists to enter their sacred precincts to give anesthetics in spite of the fact that they are commercially exploiting nursing anesthesia, but their method of making this pay a profit is to swat the patient with an extra fee for anesthetic service. The nurse who is exploited puts in an appearance in the operat-

ing room, in which the medical or dental anesthetist is giving the anesthetic, and inquires if she can be of service. Naturally, under the circumstances, her offer is declined, but the patient has to pay the professional anesthetist because he wants his life adequately safeguarded in one of its most crucial crises, and the hospital includes the anesthesia fee for nursing anesthesia in the hospital bill, although no service has been rendered, and the patient pays twice.

In some hospitals the rate for nursing anesthesia under this plan is as high as \$25 an hour or fraction thereof, so it is apparent that these hospitals consider themselves privileged to charge patients on the basis of professional rates of fees, not only for actual nursing anesthesia, but also when no service at all has been rendered.

There is just one purpose behind such action and that is an effort on the part of such hospitals to make patients dissatisfied with professional anesthesia on account of the prohibitive double cost. The whole scheme involves a matter of obtaining money under false pretences and it amounts to a form of petty larceny at the expense of the dangerously sick.

The deplorable feature of this situation is that some surgeons are participating in it to their eventual destruction. They have not enough vision to realize that hospitals indulging in these tactics are on the way to using the same methods on the surgeons themselves. Already there is an open movement within hospital associations to do without a medical and surgical house staff and turn this work over to nurses. In the near future certain surgeons will be told by their hospitals that the hospital will dictate their fee or salary, or they can get out. Some staffs are allowing themselves to be controlled by this threat.

The superintendent of one of the largest hospitals in Chicago returned from a 1922 hospital meeting and broached the matter of minor surgery by nurses to his staff. He was told that the moment he or the hospital board attempted to throw nurses into the practice of surgery, the hospital would have to find an entirely new medical and surgical staff.

Doctors do not seem to realize just how dependent hospitals are on the medical profession and any staff has the solution of this problem right in its hands by telling patients

frankly of the entire situation and also bringing it to the attention of the public through the press and business and commercial organizations and federations of women's clubs. Further, nothing more than the mention of a resignation of the entire staff and a submission of the reasons to the county society is seldom needed.

A large number of right-minded, ethical surgeons are doing all they can in the premises by employing professional anesthetists, in spite of the attitude of the hospitals in forcing their patients to pay double fees for anesthesia, and it would seem that the organized profession should get behind these men and their anesthetists and enable them to make their hospitals reform and stop exploiting their patients.

—*Exchange.*

THE FIFTH AVENUE HOSPITAL

The Fifth Avenue Hospital is the result of the consolidation of the old Hahnemann Hospital and the Laura Franklin Free Hospital for Children. For several years before the war the trustees and medical staff of the Hahnemann Hospital had been considering replacing the old building, which had served the public for more than fifty years, with a new structure, so planned that the "ideal type of hospital service might be available to all persons, irrespective of class, creed or color." Investigation showed that the really poor are provided for in the city hospitals, and in privately endowed institutions. Persons of unlimited means may avail themselves of all the advantages and luxuries to be purchased in modern hospitals. But a large middle class exists, consisting of people of limited means who do not wish or need to be charity patients, yet who are not able to afford the privacy and care that they would like to have. "To provide this in-between class with all of the necessary comforts and the privacy of a single room is the great ideal around which this hospital has been constructed," says the present director, Dr. Wiley E. Woodbury, "but, in order that all classes may be accommodated, ample provisions have been made to care for persons of unlimited means as well as for those who are extremely poor. The rates authorized by the board of trustees are from nothing up."

A most imposing and impressive structure the Fifth Avenue Hospital is, occupying a whole block front on Fifth Avenue, between 105th and 106th Streets, just across from the Central Park Horticultural Gardens. The architecture might be described as an adaptation, to a modern sky-scraper type of building, of North Italian Renaissance lines and a Spanish Mission roof. The building is nine stories high, with a central dome containing three more stories, and with



Fifth Avenue Hospital

a basement and sub-basement. It is constructed in the form of an *x*, since this plan provides each of its three hundred rooms with outside lighting and exposure. The character of the rooms, and the fact that each patient has a private room, except on the children's floor, are the special and outstanding features of the hospital. Another feature is the doing away,

as far as is compatible with medical standards, of everything suggestive of a hospital atmosphere. This has been done with notable success in the patients' rooms, which are exceedingly attractive with their pretty wooden furniture, painted in the most modern style, comfortable chairs, harmonious rugs, and, in some instances, a beautiful outlook over the park. Each room has a connecting lavatory, some have bathrooms, and others are in the form of suites. The walls are a soft French grey, and even the beds are enamelled to harmonize with the walls and furniture. On practically every floor there are waiting rooms for visitors, and these, too, are comfortable and attractive. Even the anesthetizing rooms of the operating department on the eighth floor masque their purpose in their decoration and furnishing, which resemble that of small parlors. The corridor walls are buff and tan, and further variety is added to the color scheme by having some of the rooms, among them the patients' solarium, on the tenth floor, done in a soft, greyish green. The nurses' rest room on the ninth floor is a large, sunny apartment overlooking Fifth Avenue and Central Park. Every floor has a loggia overlooking the park where patients or staff may sit or walk in the open air, in case they are not able, or do not wish to take advantage of the four promenade roofs and the tenth floor. Here on the roof the patient may remain all day, yet receive as usual his regular meals and treatment.

The first floor of the hospital contains the offices of administration, dining rooms for the resident staff and nurses, living quarters for interns, and private suites for physicians who wish to take advantage of the facilities of the hospital. These consist of a reception room, an office, and an examining room, and are so situated that patients may be admitted by a private entrance. The social service department has its headquarters on this floor. The chief function of this department is the investigation of non-paying cases before they are admitted to hospital.

The second floor, called the Laura Franklin-Delano Foundation, is devoted exclusively to the care and treatment of children. On this floor, instead of single rooms, are large, many-windowed apartments, some of which have been divided by glass partitions into isolation cubicles. Here are also play-

rooms, both indoor and out, a school room, a dental office, and other facilities. Out-patient clinics are held here daily from two to three.

The third, fourth and fifth floors, consisting chiefly of patient's private rooms, show the x plan which is one of the features of the Fifth Avenue Hospital. The four corridors, on which these rooms open, radiate from a court in the central rotunda. Around this court are the entrances to the elevators, and opposite them are the open supervisor's office, commanding a view of the elevators, the visitors' waiting room, and the whole length of the four corridors; adjoining the supervisor's office a small service room for the preparing of special treatments; back of this a rest room for special nurses; and behind the elevators two completely equipped treatment rooms. The fourth floor contains rooms for the supervisors and the pupil nurses, and the third those for employees.

The sixth floor is devoted to maternity cases, with provisions for maternity clinics on Tuesdays and Thursdays. Here prospective mothers may be received and given two weeks' board, care and treatment, including delivery and treatment of the baby, all for the sum of \$75. This floor accommodates thirty-eight adults and forty-five babies. There are three delivery rooms, one of which is especially equipped for the care of infected cases. The rooms on this floor have been provided with sound-proof walls and ceilings, so that all noise has been reduced to a negligible quantity.

The seventh floor is much the same as the third, fourth and fifth, except that the rooms here are somewhat larger, several of them have private baths, and a number are arranged in suites to be thrown together when necessary.

The eighth floor is devoted wholly to the various scientific departments. The operating rooms are seven in number and occupy the north-east wing. These include a clinic operating room, two private operating rooms, an operating room specially equipped for genitourinary cases, with a cystoscopic room near by, a plaster room for the orthopedic service, and special operating rooms for the eye, ear, nose and throat departments. There are also surgeons' scrub-up rooms, supplied

with all the latest scientific apparatus to insure sanitation and asepsis, sterilizing units for the operating rooms, and a special instrument and supply room with the necessary articles continuously available for every type of operation. Each operating room is equipped with a recessed cabinet in the wall for dressings and supplies.

In the operating rooms the color scheme of grey is carried out in the dark grey tiling and very pale grey upper walls and ceilings, giving practically the same light effects as white. The furniture is also light grey. Regular operating hours are daily from eight a.m. until four p.m., but emergency cases are received at all hours. On this floor a reference library for the staff will occupy the space used on the other floors for the visitors' waiting room, and there is also a staff room for medical instruction and demonstration.

The south-west wing of the eighth floor contains the pathological and bacteriological laboratories. This department is equipped with a dumb-waiter service for the transportation of specimens direct from the other floors. In the south-east wing are the gastroenterology and X-ray departments, with full equipment; and in the north-west wing are rooms for special treatment and examination, with a basal metabolism apparatus, and electrocardiograph and other equipment. On this floor also, as has been said, are the anesthetizing rooms.

The ninth floor is given over to the use of the nurses; the tenth has the open air roofs, the patients' solarium, and the quarters for the animals used in experimental research in the hospital; on the eleventh is installed the automatic dial telephone, and on the twelfth the great plant of the ventilating system.

There are also a basement and sub-basement. In the latter are located the morgue, the autopsy rooms, the disinfecting and incinerating plants, the fan rooms and the boiler plant. The main basement contains one of the special features of the Fifth Avenue Hospital, namely: the central service department. This is situated in the centre of the basement, adjacent to the linen room, surgical supply department, pharmacy, store rooms, general kitchen and diet kitchen. Four electric dumb-waiters and a freight elevator transport necessary ar-

ticles from this department to the various floors of the building.

Orders for these necessaries are transmitted to the basement direct from the various floors by means of a telautograph in the supervisor's offices and automatic telephones. The general kitchen and the diet kitchen prepare the food, which is placed on trays that are immediately transferred to large, electrically heated dumb-waiters, and so carried up to the various floors. When the meal is finished, the trays are returned to the basement. The other chief department of the main basement is that of the surgical supplies. This division has the complete handling of the sterilizing of the hospital.

As the Fifth Avenue Hospital has been receiving patients since last July only, it is perhaps too early to comment on the practical working out of its departures from ordinary hospital construction, equipment and administration. Inquiries as to whether a lack of skylights and the grey wall coloring in the operating rooms might not obscure the lighting to some extent, were answered by the statement that the large, complex and specially constructed electric lights directly over the tables obviate this possible criticism. Whether or not patients may be cared for as successfully in private rooms without special nurses as in wards remains to be proved by the Fifth Avenue Hospital system. According to this system the patient, when he wishes attention of any kind, presses a button in his room, which turns on a green light in the corridor above his door, and another in the supervisor's office. These lights stay on until the nurse goes to the patient's room and puts them out by pressing another button. If the patient is considered too sick to be left alone for part of the time, he is required to have a special nurse. All delirious patients, patients recovering from the effects of anesthetics, and, of course, critical cases of all kinds are also required to have special nurses.

There are various other minor points, the working out of which will be watched by New York nurses and physicians. Members of the staff report that to date the system as a whole has worked most satisfactorily, with minor modifications, as methods are being tried out. The administration is most cordial in its welcome to those interested in its plans and problems, thus enhancing, in contrast to an institutional or

hospital atmosphere, the more cheerful and informal feeling given by pleasant, homelike surroundings, which have been proved not only possible but practicable, even in an institution so huge and so highly systematized as the Fifth Avenue Hospital.—*The New York Medical Journal and Medical Record.*

SANATORIUM FOR PRISONERS OPENED

The new state tuberculosis sanatorium for inmates of Michigan's penal institutions is completed and ready for occupancy, according to information received from Dr. R. M. Olin, commissioner of the Michigan department of health. The building has been erected since July 1, 1922, at a cost of \$10,000.

The sanitorium is one of the tangible results of the work of the health department's bureau of institutional health administration, organized in September, 1921, to cope with the deplorably unhealthful conditions then existing in state prisons and reformatories. The surveys made by the department of health showed that tuberculous prisoners were quartered with those who were not infected with the disease and that the living conditions were such as to encourage a rapid spread of tuberculosis.

Members of the health department believe that the new sanatorium will aid in the cure of persons who have already contracted the disease and halt its spread among other prisoners.

Another undesirable feature of Michigan's penal system was uncovered by this survey. It is the indiscriminate housing of mentally subnormal persons with those of normal mentality. A psychiatric unit, authorized to investigate the mental status of incoming prisoners in these institutions has now been made possible by the state administrative board.

If present plans mature, this clinic will attempt to solve the problem of segregation.—(*Exchange*).

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BOOK REVIEWS

An Outline of the Pirquet System of Nutrition, by Dr. Clemens Pirquet, Professor of Pediatrics at the University of Vienna, Austria, Philadelphia and London: The W. B. Saunders Company, Canadian Agents: The J. F. Hartz Co., Limited, Toronto. 1922. Price, cloth, \$2.00 net.

This is a capital little book, one that will be found most useful not only to pediatricians, but also to those studying dietetics. Its pages are devoted to such subjects as "Feeding in the first year of life," "The nutritional treatment of tuberculosis," and "Proper feeding as preventive medicine."

The Middle of the Road, by Sir Philip Gibbs, McClelland and Stewart, 215 Victoria Street, Toronto. Price, \$2.00.

This is a most entertaining story, written by Sir Philip Gibbs. It is quite absorbing and without a dull chapter. We would suggest that our readers forget not to take a copy with them on their summer vacation.

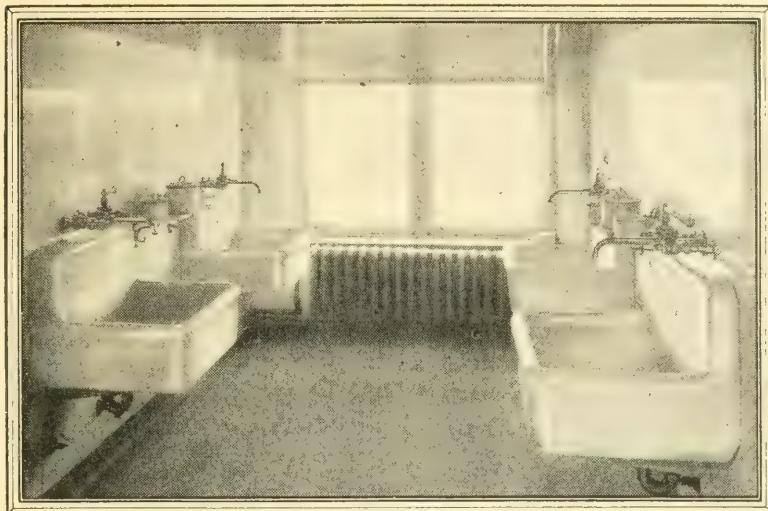
Way of Revelation—A novel of five years—by Wilfred Ewart, London and New York: G. P. Putnam's Sons.

It is difficult for many people, and particularly those who have suffered, to even handle a book whose story is based upon the recent dreadful European War. Mr. Wilfred Ewart's "Way of Revelation" is, however, an exception. It is a work of fiction of very considerable merit and we do not hesitate to recommend it. The description of life in billets is intensely fascinating and the author's language adds materially to the interest found all through the novel.

SIGNALLING SYSTEMS IN HOSPITALS

Geo. E. Mills, Sales Engineer, Signal Systems, Ltd.

Recent years have brought about many discoveries in the medical and electrical branches of science. Electricity and electrically operated appliances are continually being used by the medical profession, and the demand for reliable electrical equipment is becoming acute. Hospital Signal Systems are a small but important part of the electrical field used by the medical world, and it doubtlessly would be of great advantage to doctors and those connected with the management of hospitals to investigate the merits of the various systems. Realizing the importance of Hospital Signal equipment, manufacturers have placed on the market a number of high grade systems, some of the most important being: Silent Nurse Call Systems, Doctors' Silent Paging Systems, Fire Alarm Systems, and Interior Telephones. The value of Nurse Call, Fire Alarm and Interior Telephone Systems, need not be



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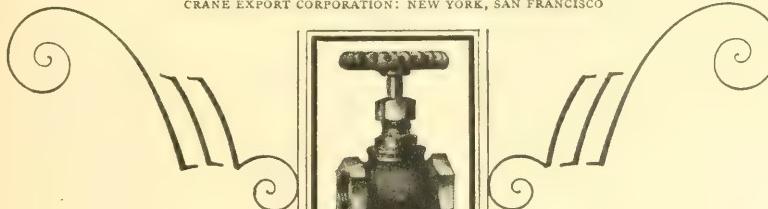
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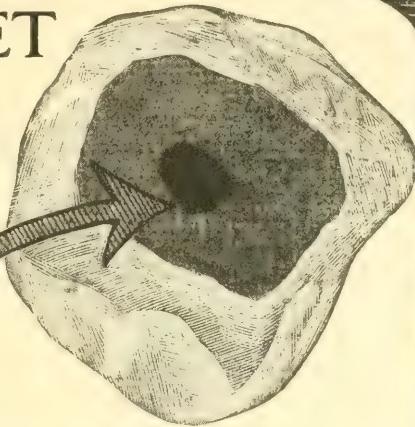
commented upon. However, Silent Doctors' Paging Systems and In and Out Annunciators are not so well known, though doubtlessly in the near future they will become part of every hospital. With the Doctors' Silent Paging System, a doctor or official can be quickly located throughout the hospital without any noise or confusion, by means of light signals displaying a combination of letter and figure. How many times does it not happen that a doctor, having an important private practice, upon entering a hospital becomes difficult to locate, and his private practice very often suffers. With the adoption of the Paging System, such conditions are reduced to a minimum. When hospitals are equipped with In and Out Annunciators it is possible to see at a glance whether certain parties are on the premises without inconveniencing or restricting those who use the Annunciator. This is accomplished by placing a small sending station at the various entrances connected to one or more indicators. The brief description given only leads to an insight of the numerous systems that are available. There are companies specializing in equipment of this nature, who would be only too pleased to act in a consulting capacity and lay out Signal Systems that meet all requirements; therefore, no institution should deny themselves this valuable service.

KELLOGG'S BRAN

Results from prescribing Kellogg's Bran have been so generally up to expectations in the relief of even aggravated cases of constipation that this important cereal is becoming a sort of standby among physicians.

Kellogg's Bran ranks very high in food value aside from its beneficial effect on the intestines, which, as you know, is very largely mechanical. As a roughage, the bulk of bran is invaluable in cleansing the alimentary tract. This important bulk is only found where the actual bran content is practically 100 per cent. This accounts for the popularity of Kellogg's among physicians because Kellogg's is *All Bran*. Kellogg's can be prescribed with confidence. Unlike unpalatable common bran, Kellogg's Bran is really delightful because it is cooked and "krumbled" and ready to eat as a cereal, mixed or cooked with other cereals or used in baking or cooking. Physicians are advising the use of Kellogg's Bran in families, not alone as a relief from constipation, but as a very active, satisfactory preventative. Bran is used in baking and cooking with fine results. It is an interesting way to have every big and little member of the family get their share. And, it means so much to health.

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Liquids follow lines of least resistance. The skin acts as a porous membrane separating two fluids of different densities—Antiphlogistine and the blood. An interchange occurs between their fluid constituents, endosmotic or exosmotic according to the direction of least resistance.

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As requirements become more finely developed it is necessary to pay greater attention to the selection of hospital flooring. "Dominion Battleship Linoleum" is one of the most durable floor coverings known. For hospitals, sanatoria and such buildings, where severe tests require floors of first quality, it is highly desirable and most satisfactory in service. It eliminates strain because of the soft, resilient walking surface it affords; it promotes comfort because of this restful treading surface; it ensures permanence and becomes a seamless, crevice-less floor when properly laid with waterproof cement. Its construction makes it distinctly germicidal—an important consideration in a building housing the sick.

The grades in which "Dominion Battleship Linoleum" are made permit of its selection for every type of building, depending upon the requirements. Grade "AAA" is six millimetres thick, grade "AA" 4.50 millimetres, and grade "A" 3.60 millimetres. Length of rolls, twenty-five yards in each grade. Two other grades are available as Plain Linoleum, "B" three millimetres thick, and "D" 2.05 millimetres. In addition to being made in two yard widths, "A" and "D" grades are to be had four yards wide.

Four shades are available: plain brown, green, terra cotta and grey. Various grades are available to suit every requirement, ranging from the British Admiralty standard six millimetres (one-quarter inches) to a lighter grade of about two millimetres. To obtain satisfactory results the manufacturers recommend the engaging of expert laying service. This is supplied by many floor covering merchants, who, for a nominal charge, lay this covering according to detailed specifications, thereby ensuring permanent, satisfactory results.

AN OLD FIRM UNDER A NEW NAME

On July 1st, the well-known firm of Hudson-Parker, Ltd. became Corbett-Cowley, Ltd. It really is a change in name only, for Messrs. Corbett & Cowley have been in control for a considerable length of time, having been identified with the business since its inception, and it is under their management that the name Hudson-Parker has come to be identified with high-class hospital apparel and bedding. Both are practical men who understand what is required for hospital use, and have been inspired with the determination to make their product one to be proud of. Operating their own factory, they have featured the "Made-in-Canada" idea—not for the purpose of seeking business on sentimental or patriotic grounds, but to demonstrate that, in the matter of quality, Canadian-made products can, and do, successfully compete with the best



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Physicians in good standing are cordially invited to visit the Battle Creek Sanitarium and Hospital at any time for observation and study, or for rest and treatment.

Special clinics for visiting physicians are conducted in connection with the Hospital, Dispensary and various laboratories.

Physicians in good standing are always welcome as guests, and accommodations for those who desire to make a prolonged stay are furnished at a moderate rate. No charge is made to physicians for regular medical examination or treatment. Special rates for treatment and medical attention are also granted dependent members of the physician's family.

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imported goods. The plan of selling direct to the hospitals has also been an important factor in the development of the business to its present standing. Ordering by mail has been made an easy matter, thus placing hospitals in the smaller cities on an equal footing with the larger institutions in the matter of purchasing their apparel and bedding. The business will be continued in the present quarters: the Darling Building, 96 Spadina Avenue, Toronto.

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Away back in the year 1878, the late Mr. Foster P. Rhines, after having already spent twenty years of his life in the study of scientific milling, determined to organize a new company which would specialize in the manufacture of Genuine Gluten Flour, Genuine Whole-Wheat Flour and Genuine Graham Flour; accordingly, The Farwell & Rhines Co. was organized and for the past forty-four years this company has given its entire attention to the manufacture of these flours. In order to have a trade mark, which would stand for genuineness and absolute purity, the company conceived the idea of adopting for its trade mark, the Criss-Cross Lines and, accordingly, F. & R.'s flours and cereals have since that time been known as F. & R.'s Celebrated Criss-Cross Cereals. During the many years that flours were not under the vigorous control of the Government, as they are to-day, the Criss-Cross Cereals meant a great deal, inasmuch as it was the purpose and determination of this company to see that nothing but the finest quality of goods ever went into a bag or carton bearing the Criss-Cross Lines, which measure up to the highest standard of purity. In other words, during these many years, there were hundreds of imitation Gluten flours, imitation Whole-Wheat flours and imitation Graham flours; of course, it is now becoming a general practice in nearly every country to adopt standards to which a flour must comply in order to be branded the genuine product; this serves as a protection to the consumer, and even the housewife, who is not supposed to be posted in scientific milling, is quite sure to-day to receive the genuine product provided it is so branded on the bag or carton. It, of course, is necessary for the housewife to read carefully the label on the container and make sure that the manufacturers claim the flour to be genuine. F. & R.'s Genuine Gluten Flour contains forty per cent. of gluten and complies in every detail to the standard set by the United States Department of Agriculture. This flour contains as large an amount of Gluten and as small an amount of carbohydrates as it is possible to leave in a pure-wheat flour and have it so that a loaf of bread can be made from same.

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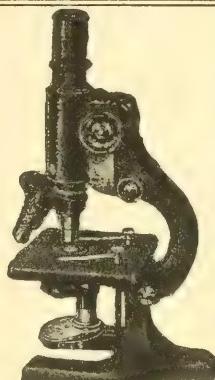
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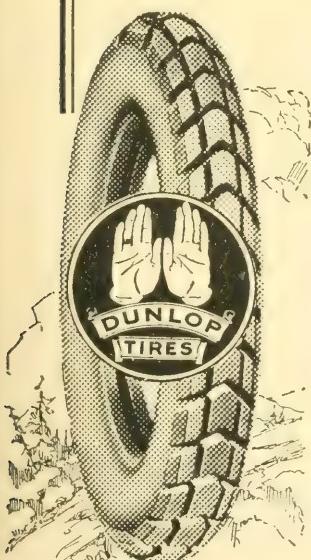


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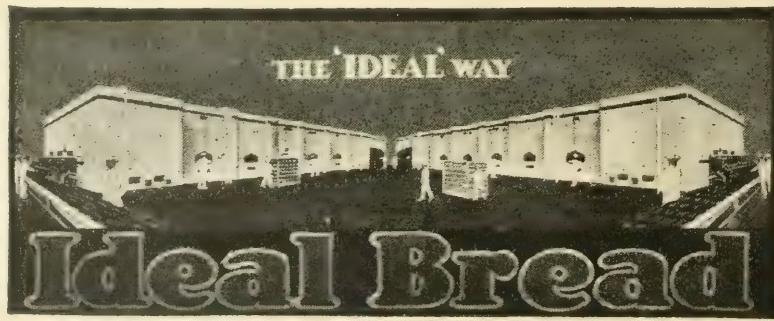
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THE HOSPITAL WORLD

Vol. XXIV

Toronto, August, 1923

No. 2

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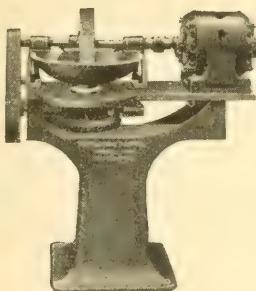
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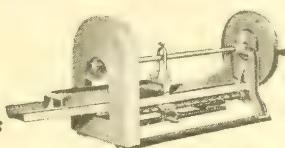
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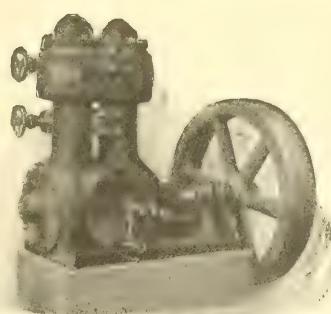
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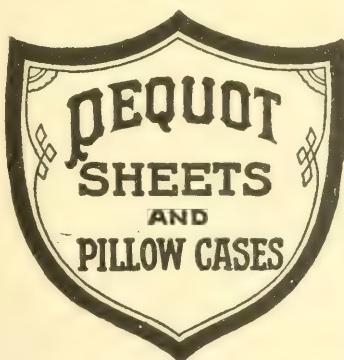
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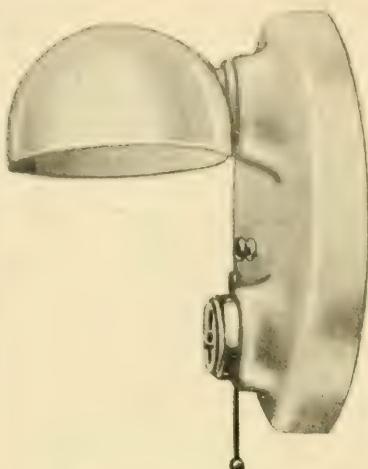
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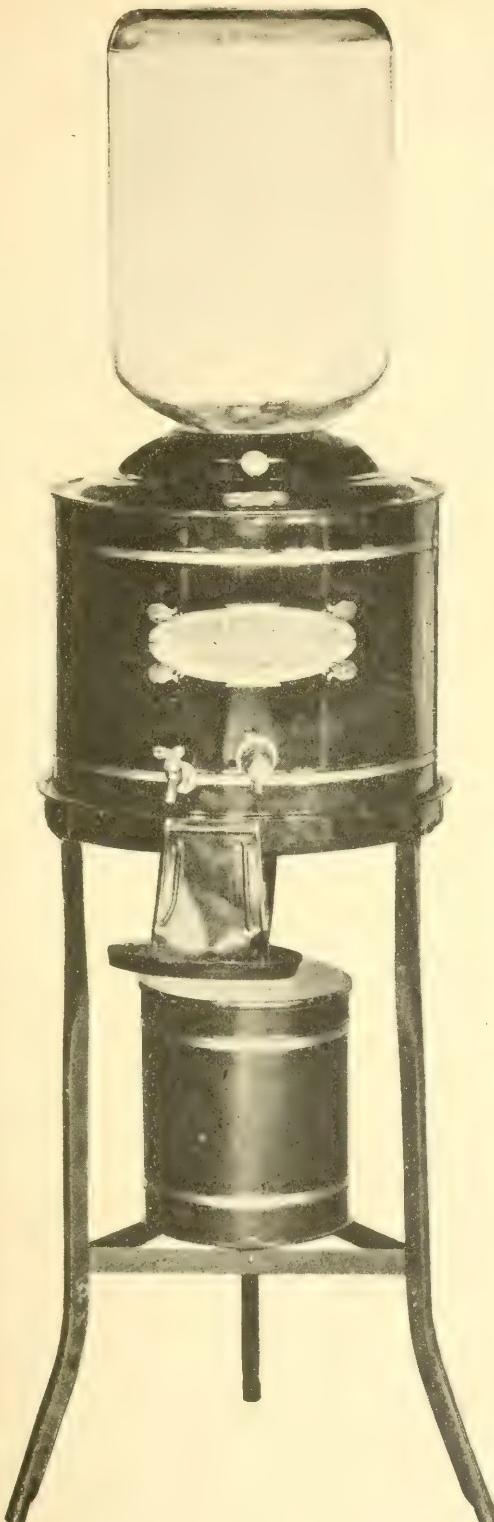
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The Hospital World

TORONTO, CANADA

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Public Charitable Institutions throughout the British Empire.

Vol. XXIV.

TORONTO, AUGUST, 1923

No. 2

Editorial

Massachusetts in the Van

The most important gathering of health workers ever held in New England took place in Springfield, Mass., recently. The *Transcript* says the conference brought to the surface the latest thoughts on the betterment of health, and that these ran in three principal currents: co-operation, prevention, and care of children. Whether the topic was mental hygiene, the new dentistry sanitation or therapy —the three dominant thoughts were there.

Dr. D. H. Thom drew attention to the two revolutions in medical thought: (1) the conservation of mental health and the preventive methods of mental ill health (in place of institutional care); (2) the care of the child instead of its neglect, as was the case formerly, when the child was left much to itself or even sacrificed to industry or economy.

Dr. H. D. Cross maintained that preventive treatment of the teeth of children must be accomplished before the age of six. The old idea was that the function of the dentist was merely to fill and repair teeth.

About ninety-five per cent. of American children show one or more defects of the teeth. Per contra: about the same per cent. of immigrant children from Southern Italy have sound teeth. The teeth of the immigrant children had (as a rule) never known a tooth brush. Further, the teeth of these foreigners after five or ten years in the United States showed the quality pretty well maintained, even in mouths that had little claim to be sanitary.

It would appear that the chief value in the use of the brush is the washing the mouth gets in the process. The brush, however, has much educational value in establishing health habits.

Prevention begins none too soon when consideration is given to the food of the infant—that which goes to form the tooth tissue.

As to the mental health of the child, the family must be “treated” before the child is approached at all. Facilities for treatment and prevention of mental ill-health are rare. More and greater facilities must be found and thus stem the fearful tide of lunacy.

Another problem discussed at this epochal meeting was: Is the health of the child a school problem? A second: is it just a fad, and not worth the

money it is likely to cost? The astonishingly low point of the average community health answers the second question. Community interest is necessary to bring the individual man (who may be responsible for the spread of ill health) into touch with other men for the betterment of the whole. Many folks do not know enough to protect themselves from communicable diseases. It is most important, therefore, that children (our future citizens) should be taught whatever is important to their well-being.

Schools afford two important lines of work: First, to do what can be done for the child; second, to teach the child what he can do for himself. This is the foundation of the proper health education of the people: It underlies that which must support all public health movements: a good, sound, well-grounded public opinion.

A health agency must make the people understand that its work is helpful. If it does this, there will be no difficulty about the funds with which to support the work.

Deep X-ray Therapy

Reginald Morton, M.D., C.M., who visited Canada last fall, and gave a paper on the above subject in Toronto, makes a contribution to a recent number of the *Lancet* in collaboration with Dr. Harrie B. Lee.

They give brief histories of a number of patients treated "when conditions were favorable." What constitutes "favorable conditions," they admit they do not know; for cases that one would expect to do well did not do well and others in which treatment was given as a placebo at the urgent request of patients and relatives, did surprisingly well. The authors conclude from this anomalous state of affairs that technique is still faulty; but they hope with improvement of technique results correspondingly better will be secured.

The authors followed the line of treatment—prescribed by Wintz, of Erlanger—of attacking deep-seated growths by multiple ports of entry.

They emphasize, too, the importance of administering treatment in large airy rooms, seeing that patients are exposed to an air considerably vitiated.

If the patient has a red blood count of less than 4 million, a preliminary course of intramuscular injections of iron and arsenic is given. In the severer secondary anemias ultra-violet radiation is administered before raying is attempted.

In some breast cases which have been repeatedly irradiated a collapse of underlying lung takes place.

Morton and Lee sum up by saying that the deep X-ray treatment of growths has now fairly established itself as a method of dealing with cases when nothing else can be done. The results in all cases make treatment worth while, and in "a few cases border on the miraculous."

On Writing

Dr. John Brown, of Edinburgh, says in one of his essays (all well worth reading) that their medical writers in those days, with a few signal exceptions, wrote ill—being slovenly, diffuse, often obscure, and curiously involved. He attributes this to the enormous amount of merely professional knowledge a man was expected to master before he wrote on any subject, and the absorbing nature of the new methods; as a consequence, the ignorance of general literature, and the much less association by men of medicine with men of letters then than formerly.

Our author contends that Arbuthnot was not the worse physician, and all the better writer, from his being the companion of the famous wits whose good genius and doctor he was. Currie, Aikin, Gregory, Heberden, Cullen, Ferriar and Gooch were all the more powerful, and all the more permanent as medical authorities, from their having learned, by practice and example, to write forcibly, clearly, compactly, and with dignity and grace.

Says Brown: "The turbid, careless style, constipated or the reverse, by which much of our medical literature is characterized, is a disgrace to our age, and to the intelligence, good taste, and good breeding of our profession, and mars inconceivably the good that lies concealed and bungled within it."

"Let no one despise style. If thought is the gold, style is the stamp which makes it current, and

says under what king it was used. There is much in what Buffon says—"Style is the man himself."

To get a good style, Dr. Brown recommends us to keep good company and do our best, and "you will write and speak and act like a gentleman, because you think and feel and live with gentlemen."

Acute Suppurative Otitis

A writer in the *Lancet* states that as soon as earache occurs, the meatus should be cleansed. One in sixty carbolic solution may be used. Every four hours the meatus should be filled with a warm solution of carbolic in glycerine (twenty-five grains to the ounce), retained three minutes. A pad of cotton should then be applied and over it, a hot water bottle.

The drum should be incised under a general anesthetic if there is bulging or a bright velvety-red appearance, or when severe earache persists for twenty-four hours without improvement. A gauze drain should be placed in the meatus and a large pad of wool applied. The pad is changed when wet; the drain, by the doctor; If personal attention is impossible, the gauze drain may be removed at the end of twenty-four hours and the carbolic and glycerine drops used.

Pain usually ceases in a few hours after free discharge is established and the temperature becomes normal in two days.

If pain and temperature persist without improvement for more than three days—especially if mastoid tenderness be present or if discharge has ceased—the antrum and mastoid cells must be opened without further delay, unless the perforation has closed, when paracentesis should be repeated.

Should a child come first under attention with discharge a week old, with pain, fever and mastoid tenderness, hot fomentations and three-hourly syringing with hot one in sixty carbolic lotion will often bring about a cure.

Co-operation in Sickness

The workers in old Madrid, Spain, have maintained, since 1904, a health department in the co-operative society. It provides complete medical service for \$8.00 a year for each member. There are seven clinic hospitals in different parts of the city, each equipped with about ten beds, an up-to-date operating room, a dental clinic, consulting rooms, an immaculate tiled kitchen, and a garden for convalescents. Each has a staff of physicians, surgeons and nurses. The drug store connected with each hospital furnishes medicines, free of charge, to the members, and sells to non-members at the current price. The co-operative society supplies the hospitals with provisions. Each member pays sixty-six cents a month to the society. For

this, besides the benefits of membership, he receives free medical service, major operations and advice at any time.

In New York City a similar experiment is being made by the Manhattan Health Society.

Mr. Richard Bradley, of Boston, has been advocating this plan for some years. It sounds sensible.

Mental Nursing

"It is practically impossible to find a nurse in this community who is willing (perhaps anxious) to look after a mental case in private."

Such is the statement of Dr. Mathers, Director of the psychopathic clinic in Winnipeg. This was due (he added), to the feeling nurses had that mental cases were hard to look after, and that the work was arduous, which was absolutely incorrect.

Nurses from the General Hospital, Winnipeg, go to the psychopathic clinic for two months' training. Dr. Mathers thought that was not long enough. He would like to make it possible for the nurses from any hospital to take the training—at least, those who would choose to train there. It was important that nurses should receive instruction in disorders of this most important part of the individual, in order that they may go out and help to spread the new doctrine regarding mental disease.

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Editors:

ALEXANDER MacKAY, M.D., Inspector of Hospitals, Province of Ontario.

JOHN N. E. BROWN, M.B., (Tor.), Ex-Sec'y American and Canadian Hospital Associations, Former Supt. Toronto General and Detroit General Hospitals.

M. T. MacEACHERN, M.D., Director-General, Victorian Order of Nurses, Ottawa.
W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont., Consultant, Toronto Hospital for Incurables.
MAUDE A. PERRY, B.S., Supervising Dietitian, Montreal General Hospital

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THOMAS BEATH, M.D. (late Superintendent, Victoria Hospital, Winnipeg), Raleigh, N.C.

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Original Contribution

THE HOSPITAL NUTRITION CLINIC

MISS MAUDE A. PERRY, B.S., SUPERVISING DIETITIAN,
MONTREAL GENERAL HOSPITAL.

The alarming prevalence of malnutrition of growing children has awakened the interest of hospitals as well as of schools in the problem of alleviation of this condition. This interest is another indication of the increasing realization of thinking people, that an ounce of prevention in this direction is worth more than a pound of cure. In connection with large hospitals in Boston, New York, Chicago, and other large cities, clinics for these children are being conducted with the purpose of discovering and correcting the faults responsible for the retardation of children in school, and for serious defects of nervous and physical defects in adult life.

Physicians of to-day concede that malnutrition, when not accompanying serious illness, has been overlooked and neglected in the past, as few realized the handicap under which the under-nourished child has labored. Dr. Wm. R. P. Emerson of Boston, who is perhaps our leading authority in nutritional work says "one child in every three is under weight," and that these children are stunted mentally as well as physically and that unless corrective measures are instituted at the proper time, "these children will remain so throughout life." In every case of malnutrition of children, free from organic disease, the cause is remediable if taken in time. Physicians experience great difficulty in obtaining access to these cases unless the child is really ill. One physician remarked that he makes twenty calls to correct illnesses caused by dietary indiscretions, to each call where he is given an opportunity to do preventive work. There are many reasons why this is so. Many malnourished children have round faces and

look well when dressed, because the easily distinguishable signs of malnutrition, winged shoulder blades, protuberant abdomen and flabby muscles, are hidden by the clothing.

Children between the ages of two years and sixteen years suffer most from undernourishment. This is usually not discovered until some undue strain reveals the unsuspected weakness. Children who are run down, frail, delicate, thin, anemic, small for their age, always tired, easily upset, irritable over trifles, restless, nervous, difficult to manage, finicky about foods, and backward in school are usually malnourished.

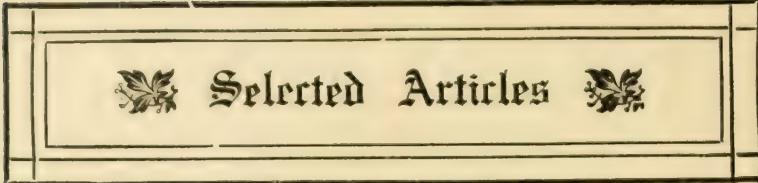
In January, 1921, we decided to start a small nutrition class at the Montreal General Hospital, in connection with our out-patient department, with Dr. A. B. Chandler as examining physician and myself as class leader. The plan of the clinic was, and still is, to accept as members of the class, children whose weight was more than seven per cent. below normal, and to instruct both parents and children in proper food and health habits; for malnutrition in the majority of cases is due more to ignorance than to poverty. We have no age limit for admission of children. Some clinics work with children of school age only, but I think that the period from two years to six is as important, if not more so sometimes, for the correction of bad food and health habits. We have even taken infants who were straight feeding, not medical cases, and have obtained good results by education of the mother. We have one baby nine months of age, who looked like an almost hopeless proposition at six weeks of age. She is fine now, gaining weight every week and as bright and happy a baby as anyone could wish to see.

The children are admitted to the clinic by request of the Out-Patients' Children's Clinic, The Victorian Order of Nurses, The Patriotic Fund, City Schools, or other social agencies. Children of any race or religion are taken. Every Saturday forenoon all children are undressed and weighed in muslin gowns made for this purpose, to avoid variation of weight occasioned by change of clothing. The weight is charted and the child who heads the class by the greatest gain is given a prize in addition to the gold star which is placed on his record. The charts are hung upon the wall so that each

child may follow his or her own progress from week to week. Each child upon admission is given a thorough medical examination and if at any time his progress is not satisfactory or he does not seem well, he is given further medical attention as seems necessary. Any defects such as enlarged tonsils, adenoids, decayed teeth or poor eyesight are remedied as soon as possible. We have also been fortunate enough to detect disease that might have gone unnoticed for some time, had the child not had the benefit of this clinic. One case of incipient hip disease was discovered at a very early stage. Neglected, this child might have been a cripple for life. She was sent to a specialist who put her into a cast and cared for her and to-day she is normal. Another child developed tuberculosis following influenza and pneumonia. She was sent to a sanitarium where she was given the proper treatment under ideal conditions and to-day she is six pounds above normal in weight and the infection is arrested, probably for her lifetime.

By class method an effort is made to teach the importance of correct food and health habits to both parents and children. I do this by means of charts, stories, games, discussions, or in any other way that seems advisable. In order to get good results it is necessary to have parental co-operation and in this we have been wonderfully successful. It is often necessary to do individual work and in cases where special instruction seems essential, one can accomplish much more if the mother understands and follows by actual observation the progress of the clinic. So the mothers come with the children and the child's chart records this with a colored star. This also minimizes the necessity of home visiting in many cases. However, we do have the invaluable aid of one of our hospital social workers. She investigates the financial and home conditions surrounding each child. In instances where she finds that the family is not able to provide at least a pint of milk daily for undernourished children, she provides this from a fund donated to the social service department by the Junior League young women who have charge of a lunch counter in the out-patient department of the hospital.

Contributing causes of malnutrition, other than poverty and physical defects, are rapid eating, improper foods, irregularity of meals, refusal of breakfast, overactivity, late hours, undue excitement, poor sleeping conditions, long hours at school, lack of fresh air, and absence of home control. Correction of even one of these has yielded great improvement in a child. It seems to me, however, that one who expects only rapid chartable results may make a great mistake in nutritional work. These are sometimes most elusive and if the circumstances surrounding each child were not known, it would be easy to come to the false conclusion that our work was not obtaining results. From experience, I know that though many cases of very slow improvement cannot be charted at all satisfactorily, there is a real improvement in the children-long before the chart lines show any appreciable rise. They are learning truths which will affect the tenor of adult life, although family financial stringency may prevent them from obtaining full benefit of these at present time. We have some children with serious physical defects who come to us for instruction so that right living will strengthen their vitality and build a stronger resistance to disease for which they are receiving medical attention in other clinics. We plan in this work, to raise the weight of every child up to or slightly above normal, for his age and height, and in this way to improve his mental, nervous and physical faculties. When we read statistics of infant and child mortality in some localities, we find food for very earnest thought, and we cannot fail to realize that some part of this could have been avoided by broader and more widespread education of parents and children. Canada needs people who will be strong to develop her wonderful resources and to direct her future destiny, so she cannot afford to neglect the children who are her potential population.



Selected Articles

PUBLIC HEALTH NURSING

The first laws on the subject of public health nursing were passed by Massachusetts and Pennsylvania in 1911. Massachusetts appropriated \$2,000 for a district nurse, afterwards amended by striking out the limit in amount of money, and Pennsylvania permitted school boards to employ nurses. Fifteen States are to-day without specific laws on public health nursing, Maine and Rhode Island being the New England representatives in the group. Only two States, New York and Kentucky, expressly provide for the nurses, the laws of the other States being permissive. There are some curious features in the laws, for example: in Connecticut one law authorizes school authorities to appoint public health nurses, and another permits cities and towns to employ visiting nurses without specification of the department that is to employ them.

Five States may employ nurses direct, about twenty States have provision for their employment by the county, fifteen States permit cities to employ them and fourteen States, not all of them the same, extend the permission to towns and villages. General public health nursing is authorized in some nineteen States, school nurses in sixteen States and tuberculosis nurses in ten States. Indiana provides for nurses in mental hygiene, Montana for child welfare, Delaware for midwives and Idaho and Wisconsin for social work nurses. The health authorities direct the nursing work in twelve States, educational officers have the authority in twelve States, county commissioners have the management of the nurses in four States, private agencies with the help of State funds administer the work in three States, and in seven States there are laws which do not specify the precise official body which is to manage the nursing work.

In Alabama full-time county health officers have charge of public health work with authority to employ physicians, nurses, etc. In California, cities, towns and counties through their governing boards are permitted to employ properly qualified nurses. A later act specifies that nurses shall be registered. Connecticut has already been spoken of with reference to its double lines of control. In Delaware boards of education may employ school nurses and the State board of health is authorized to expend \$2,000 for a full-time, registered, trained nurse to educate and supervise the midwives. The Georgia law permits boards of health to employ visiting nurses for the examination of school children. Idaho authorizes county commissioners to employ graduate, trained nurses for schools, for the poor of the county, to give instruction of a preventive character with reference to tuberculosis, to be visiting nurses and to act with juvenile courts.

Indiana requires medical inspection in the schools of cities of 100,000 of population and nurses may be here employed. Hospitals for the insane are authorized to employ visiting nurses and in cities a limited amount of the tax levy may be given to voluntary public health nursing associations for their work. In Iowa boards of supervisors, city and town councils and school boards are empowered to employ public health nurses and may co-operate for the purpose. Kansas authorizes the first and second class cities to finance to a limited extent the work of nursing associations.

Kentucky established in 1920 a bureau of public health education at the University of Louisville, also a bureau of public health nursing to co-operate with official and voluntary agencies in the State. The State of Kansas will subsidize any county, district or tuberculosis association not operated for profit, for the employment of a registered nurse. Maryland leaves the whole matter for nurses in the hands of its State board of health. In Massachusetts towns and cities may employ nurses. School committees may appoint nurses but where school medical inspection is vested in the board of health, the latter shall appoint them.

Michigan permits the inhabitants of any town or towns jointly, to grant money for a public health nurse. She is prohibited from making diagnoses or prescribing drugs or treat-

ment. No person who objects, or minor whose parents object, shall be subjected to physical examination. Sex hygiene shall not be taught by nurses in the public schools. In Minnesota city, town, village or county authorities may employ public health nurses registered in the State. "Expenses" is held to include offices with furnishings and supplies, transportation, travelling expenses, telephone, and clerical help incidentals. In Missouri on the request of an anti-tuberculosis association the city or county authorities may employ a tuberculosis nurse. On petition of 250 taxpayers the city council or county court shall be bound to provide such nurse or nurses. In Montana school boards may employ registered nurses. In Nebraska the governing bodies of the communities may employ a visiting community nurse and for salary and expenses a tax of not more than five mills may be levied. The nurse may be given police power. Cities may employ nurses to be paid for out of the general fund. There is a referendum clause covering the expenses of the nurse. In New Hampshire the towns may subsidize visiting nurses' associations. In New Jersey the registered nurse shall be a tuberculosis nurse and her duties in connection with that disease. New York has a division of public health nursing in the State Health Department, with a good deal of special legislation on the duties of such nurses. North Carolina provides for a training school for nurses at the State Sanatorium. North Dakota gives county commissioners authority to approve bills and consider recommendations for service when presented by any town, county, district or State antituberculosis association. Physicians and registered nurses for schools may be employed by the county authorities. In Ohio the local board of health may appoint nurses. County commissioners may appoint nurses for tuberculosis. School nurses are also provided for. Oregon provides for public health nurses in tuberculosis work. Pennsylvania places little restriction on the employment of nurses for school, further than that they shall be graduates of reputable training schools.

South Carolina provides for school nurses for medical or dental examinations of school children. In South Dakota the county board of health files an application for one or more

nurses. The county commissioners will then consider the petition. They may appoint without the petition. The nurse must be termed "county nurse," and wear a uniform. When not needed by the county the nurse may be employed by cities, towns, associations or private individuals. The Utah law authorizes the State board of education to appoint a director of health education to supervise health education in the schools, subject to the consent of parents. School nurses are provided for in the general plan. In Vermont the medical inspector of the schools may be a physician or a nurse. Municipalities may appropriate money for a district nurse. Virginia appropriated in 1918 the sum of \$10,000, and in 1922 the sum of \$15,000 for 1923 and the same for 1924, for a unit of doctors and nurses to do tuberculosis work. In Washington the board of county commissioners is empowered to employ tuberculosis nurses. If there is a county hospital the nurses will be under the control of the hospital. In West Virginia boards of education may employ school nurses.

—*Selected.*

CHRONIC MYOCARDITIS

Henry A. Christian (*Journal A.M.A.*, June 22nd, 1918) presents a clinical study of that form of cardiac disease which is characterized by the signs and symptoms of a failure of the heart to function efficiently and by the absence of valvular lesions. The symptoms are those of cardiac incompetency of greater or less severity. To this condition the name chronic myocarditis is given for want of a better. In a series of cardiac cases seen during a period of three years in general hospital wards there were 367 without organic valve lesion—that is, chronic myocarditis—and 359 with organic valve lesion. In a series of 107 consecutive autopsies on patients with cardiac disease who were over fifty years of age, mitral endocarditis was found in only two, confirming the rarity of organic mitral lesions in persons past middle life. Chronic myocarditis was found more frequently in males than in females, in the proportion of 240 males to 167 females and it was most frequent in the decade between fifty-one and sixty

and relatively uncommon below the age of forty. In respect of the etiology of the disease analysis showed that relatively few of the patients had suffered from rheumatic fever; the Wassermann reaction was positive in only thirty-five out of a total of 369 patients tested. Chronic alcoholism was present sufficiently often to suggest its having played some rôle, but analysis of the cases did not seem to point to its having been a factor of much etiological importance. Hypertension seemed to play a part in less than half of the patients and neither it nor nephritis seemed to have very great etiological significance, especially since these conditions might have been due to the same factor which caused the cardiac condition, or might have been purely secondary to the cardiac disease. Coronary sclerosis was a factor of importance in only about half of the cases. The commonest cardiac lesion was increased in the interstitial connective tissue, but this was absent from many of the cases which had presented typical clinical pictures. Clinically, besides the usual symptoms of cardiac weakness or loss of compensation, the heart was usually found to be enlarged, a systolic apical murmur was usually present, and about half of the cases showed auricular fibrillation or flutter, or some disturbance in the conduction system as shown in the electrocardiogram. Digitalis was of great value in the earlier breaks in compensation, but of little help in the later.

PRACTICAL POINTS FOR PUBLIC HEALTH NURSES

Miss Frances V. Brink, Superintendent of Nurses for the Minnesota State Board of Health, in an article in *The Public Health Nurse*, outlines the following ten points which she suggests every county public health nurse should keep in mind:

1. Do not *diagnose*. Do not use curative methods without a physician's orders and a parent's permission. Do not take children to clinics without parent's permission.
2. Do not confide your difficulties and criticisms to the teachers and town people. Take them to your nursing committee.

3. Do not make of your office a reception room for teachers or friends. Keep your office private, for patients, old and young.
4. Attend as many nurses' district, state and national meetings, conventions and institutes as possible.
5. Do not fail to demonstrate public health nursing through necessary bedside nursing, whenever possible.
6. Gain your teacher's confidence and give information as to how she may assist in bettering the physical condition of pupils.
7. Remember that one hour of home calling is worth more than four hours in the office.
8. Do have a plan of work most definitely mapped out. System accomplishes much.
9. Do not give up your work in the community in a short time after entering because it seems discouraging. This is pioneer work.
10. In case of a reported epidemic of contagious diseases in any part of your country, be ready and willing to offer assistance to the Health Officer of the district where the epidemic exists. If the Health Officer makes a request for your assistance, drop the routine work and answer this request.

Canadian Hospitals

EARLY HOSPITAL DAYS

With happy reminiscence and the renewal of former student friendships, the Alumnae Association of the Western Hospital Training School for Nurses celebrated the twenty-fifth anniversary of the institution at a reception and at home held in the hospital assembly-room on May 25th.

Preceding the programme the members, several of whom had come from as far as Prince Rupert on the west and Halifax on the east for the occasion, gladly availed themselves of the opportunity of chatting with the classmates, supervisors and superintendents who had helped to make their particular

three years of training a memorable experience. In the receiving line were Miss Jessie Cooper, president of the Alumnae, and the three past presidents, Mrs. Gilroy, Mrs. Heuston and Mrs. McConnell.

Mrs. Yorke, one of the first three graduates of the school, and first president of the Alumnae, presided over the gathering in the assembly hall. A message of welcome was brought by the Hon. Thomas Crawford, who has been chairman of the Board of Governors for the past eighteen years.

Some twenty-seven years ago the Western Hospital began its career as a modest dispensary on Euclid Avenue, according to Dr. E. A. McCullough, first medical superintendent of the hospital, who briefly traced the growth of the institution. Recognizing the need for hospital facilities in the western part of the city, several medical men joined their forces and were able to obtain a double house on Manning Avenue. In a very short time, however, this was found inadequate, and the south wing of the present building on Bathurst Street was erected.

From the first pupil nurse, Mrs. McConnell, came a vivid picture of the old days. In April, 1896, she entered the hospital, then on Manning Avenue, as a pupil nurse, and helped to care for the fourteen patients. Her course extended over only two years, and during that period she and the second student were presented by the governors with a handsome bicycle to be used on "half-days off."

Of the first class of five, three were present last night. There were now more than 300 graduates, and special pride was felt for those of that number who had offered for service overseas. One, Miss Lena Davis, had made the supreme sacrifice, and another, Miss Drysdale, had been decorated with the British Red Cross and the French Medal d'Honneur.

Flowers were presented to Miss McKee, present superintendent, and to four of the former superintendents who were present. Mrs. Skeans (Miss Hutson), Mrs. Shaw (Miss Smedley), Mrs. Keddie (Miss Bell), and Miss Ellis. Bouquets were also received by Dr. Stowe-Gullen and Miss Cooper.

Dr. Stowe-Gullen invested eight members of the Alumnae with life memberships, the first in the name of the late Miss

Lena Davis, going to her mother. Dr. John Ferguson read a message from Superintendent Tomlin. Refreshments were served at the close.

COMPLETE PLANS FOR HOSPITAL EXTENSION

Plans are already being prepared for the erection of a new wing to St. Michael's Hospital, on the Victoria Street property, recently purchased by the hospital authorities.

Though these plans have not as yet received the final endorsement of the hospital authorities it seems unlikely that they will be materially altered and the extent and nature of the additional building is clearly indicated by them.

The new wing is to be of very considerable extent, a five storey building, with a frontage of 200 feet on Victoria Street, and 100 feet on its northern side, whilst a large semi-circular courtyard will open to the south, providing light to the interior rooms of the building.

There will be a basement and five storeys in all and their uses are as follows: Basement, a morgue and necessary caretakers' and other offices; first and second floors, a modern X-ray department, waiting and examining rooms, third and fourth floors, wards, and fifth floor surgeons' quarters, bath rooms and general lavatory accommodation.

The large courtyard is to face south with an entrance from the northwest corner of the building. It will be partly above and partly on the ground floor level; skylights and windows opening upon it to provide illumination for the X-ray, ground floor, and basement apartments.

The actual date of commencement of building operations has not as yet been determined, though it may be looked for in the not far-distant future.

WELLESLEY NURSES GET DIPLOMAS

Eighteen nurses graduated on June 21st, from the Wellesley Hospital Training School, Toronto, the exercises being held on the tree-shaded lawns, with Sir William Mulock, President of the Hospital Board, in the chair. Rev. Stuart C.

Parker gave the opening prayer, and the diplomas and pins were presented by Mrs. H. D. Warren. Mrs. Sidney Small addressed the graduating class.

The nurses graduating are: Eleanor Hinch, Grace Savage, Miriam Smith, Dorothy Denike, Eileen Harrison, Helen Cunningham, Ruth Teeter, Reina Sparrow, Fern Johnston, Winnifred Snelgrove, Evelyn Cole, Ruth Jackson, Florence McKee, Elsie Hanna, Josephine Hayden, Marguerite McConnell, Margaret Stiles, Elizabeth Crozier.

The scholarships have been awarded as follows: General proficiency, 1st, Miss Eileen Harrison; 2nd, Miss Ruth Jackson.

The Herbert A. Bruce Scholarship for proficiency in operating room technique, to Miss Eleanor Hinch.

Intermediate year: Sir John Eaton Scholarship for general proficiency: 1st, Miss Estelle Follis; 2nd, Miss Mary McClinchy.

Junior year: Sir William Mulock scholarship for general proficiency: 1st, Miss Laura Lamb; 2nd, Miss Isobel Fraser.

DEATH OF HENRY C. TOMLIN

Suddenly collapsing as he was entering the dining room of Western Hospital, Toronto, on the morning of June 18th, Henry Charles Tomlin, 312 Russell Hill Rd., superintendent of the hospital for the past twelve years, succumbed to a heart seizure, before staff doctors could reach his side.

Deceased had enjoyed but fair health for some time. Two years ago he underwent an operation and only recently with the arrival of warmer weather and the knowledge that needed extensions at the hospital which he had striven for were begun, had he seemed to really pick up.

The late H. C. Tomlin was born in Surrey, England. He came with his parents to Canada and settled in Toronto at the age of fifteen. He was first associated with his father in the bakery business and himself conducted a bakery for twenty-two years. He had been connected with the hospital indirectly and upon selling out his business twelve years ago took over the active management of the hospital.

His activities in that field are well known. The present hospital as it stands with additions under erection, lives as a tribute to his work. His whole heart was in his work and to enlarge the building to keep abreast of the growing need for more accommodation was his one desire, aside from the welfare of the patients who entered the hospital.

Possessing a kindly disposition he was respected by all. His business training and desire to help suffering resulted in many changes following his acceptance of the management. His foresight saved the hospital thousands of dollars.

ROCKEFELLER GIVES LARGE SUM TO CANADIAN AND U. S. HOSPITALS

A gift of \$150,000, to be distributed among fifteen hospitals in Canada and the United States, to promote the use of insulin in the treatment of diabetes, was announced on June 20th, by John D. Rockefeller, junior.

The purpose of the gifts, Mr. Rockefeller said, would be to increase the number of free-ward patients who could be treated with insulin, and to teach physicians, in general practice, the proper methods of employing insulin in the treatment of diabetes.

The period during which the sums should be expended was not specified, but was left to the discretion of the hospital authorities. The Canadian hospitals which were selected by the committee headed by Dr. Simon Flexner, were named as follows: Montreal, Royal Victoria Hospital; Toronto, Hospital for Sick Children, Toronto General Hospital and University of Toronto Banting-Best fund.

With the exception of the Presbyterian Hospital in New York, which will receive \$15,000, and the University of Toronto Banting-Best Fund, which will receive \$5,000, the gifts were of \$10,000 each.

HOSPITAL'S WORK GROWS

At the annual meeting of the Board of Trustees of the Hospital for Sick Children, the principal business was the election of the officers, as follows: Sir Edmund B. Osler,

honorary chairman; H. H. Williams, re-elected chairman of the Board of Trustees; Irving E. Robertson, re-elected vice-chairman of the Board of Trustees; executive committee: R. A. Laidlaw, Thos. H. Wood, Wilmot L. Matthews, with the chairman and vice-chairman ex-officio members; Watson Swaine was re-appointed superintendent and secretary-treasurer; Miss Kathleen Panton was re-appointed superintendent of nurses; the members of the medical and surgical staffs, as detailed in the annual report, were re-appointed for the ensuing year.

The board also appointed the Medical Advisory Board as follows: Dr. W. E. Gallie, chairman of the board; Dr. I. H. Erb, secretary; Dr. Alan Brown, Dr. W. H. Lowry, Dr. Edmund Boyd. Messrs. Clarkson, Gordon and Dilworth were re-appointed auditors.

The meeting recognized the great service rendered by Mr. L. Solman to the Hospital and the Lakeside Home and a hearty vote of thanks was recorded.

The meeting also recorded the thanks of the Hospital authorities for the services rendered by the John Ross Robertson Lodge in the transportation of the patients to and from the Lakeside Home.

The meeting closed with a resolution thanking the staffs, both medical and surgical—consultant and active—for their loyalty, and for the valuable services they have rendered during the year.

Statistics were tabled showing a continued increase in the hospital work, the first eight months of the current year having exceeded all records for a similar period, with 58,110 patient days, as compared with 56,842 of the previous year.

The out-patient department continues to show increased activity, a greater interest by parents, and more treatments than in the history of the hospital. The treatments to the month of May were 40,731, an increase of 661 over the highest comparative period on record.

The hospital has recently received a gift of \$10,000 from John D. Rockefeller, Jr., specifically ear-marked for the purchase of insulin and treatment of diabetics.

Dr. F. G. Banting, the discoverer of insulin, has been appointed physician to the diabetic patients in this hospital.

MISS M. A. STEWART APPOINTED SUPERINTENDENT OF LARGE HOSPITAL

Miss M. A. Stewart, who has been lady superintendent of the Guelph General Hospital for the past three years, has tendered her resignation to the board, having accepted a similar position in connection with the Children's Memorial Hospital in Chicago, which had 50,000 patients last year and enjoys a voluntary income of \$300,000 annually. She will there have an administrative staff of eighteen, of which she will be head, and will receive a salary double that she is receiving here. The Hospital Board at its monthly meeting, in accepting the resignation, passed a resolution complimenting her on the great work she had done for the Guelph General Hospital, and expressing regret at her leaving.

DIABETIC HOSPITAL IN TORONTO?

The entire second floor of the private pavilion of the Toronto General Hospital is to be given over to diabetic patients who are being treated with insulin. Heretofore, the work which was conducted in the nature of a research clinic, and all fees coming from patients receiving treatment, went to pay for the upkeep of the clinic.

Now that there is sufficient insulin, and the potency of it has about become standardized, and it is available for use by the doctors who have taken a short course on its administration, private practitioners may take their patients to the hospital as they would other patients suffering from other troubles.

It is something in the nature of an experiment, in that by a year from now it is hoped to be established just what the requirements are for diabetic treatments. Whether many practitioners from outside places will send their patients to Toronto is not yet known.

If a hospital were established for that purpose here, it would mean that Toronto would become a great centre for the treatment of diabetics.

NEED OF 8-HOUR DAY FOR STUDENT NURSES

Eighty-four young women, in smart, workmanlike uniforms, stepped up to the platform in Convocation Hall on May 31st, and, flushed and smiling with the joy of attainment after three strenuous years, returned with the diploma entitling them to the standing of graduate nurse. For every one of the eighty-four newly fledged nurses who last night left their alma mater, the Toronto General Hospital Training School, for new and varied fields of activity, the occasion was indeed memorable. The large hall was filled to capacity, four of the upper galleries being occupied by fellow-students and the remainder overflowing with admiring friends and relatives.

C. S. Blackwell, Chairman of the Board of Trustees, presided. Following the invocation by Rev. John MacNeill, the report of the Superintendent of Nurses was read by Miss Jean I. Gunn, who was given an ovation by the class of graduates facing the platform.

During the year, Miss Gunn stated, 983 applications had been received and of this number ninety had been accepted on probation. There had been a good deal of illness among the nurses during the year, continued the report, due, no doubt, to the strain of long hours and little time for necessary recreation. "If the Provincial Government would establish an eight-hour working day for student nurses, it would have a very beneficial effect as a preventive health measure and as a protection for the nurses," said Miss Gunn. Students could exist without the hospital, but no hospital could possibly carry on without the student nurse, and it was to be deplored that so frequently she appeared to be the last consideration.

Many and ingenious were the schemes evolved for the raising of \$500, the sum allotted to the Toronto General Hospital nurses as their share in the Canadian nurses' war memorial. Beds were made on weekly contract; hairdressing and manicuring became money-making occupations; shoes were shined for a consideration, and even a dressmaking establishment came into existence.

Miss Gunn referred to the fact that the two graduates who, by reason of their class standing, should have received the public health scholarships, were prevented from accepting. They were Miss Grace Margaret Hogg, of Chefoo, China, and Miss Edith Marion Ross, of Dundas, Ont.

ANOTHER SPLENDID ROCKEFELLER GIFT

Through the benevolence of Mr. John D. Rockefeller, Jr., Toronto General Hospital and the Hospital for Sick Children are each to receive \$10,000, and the University of Toronto the sum of \$5,000; the money to be devoted to research in insulin, to be conducted by Dr. Banting. Mr. Rockefeller has apparently been watching with keen interest the development of the insulin treatment of diabetes and a few weeks ago announced that he would support the work by giving the sums above mentioned to be used in the furtherance of the treatment of diabetes among the indigent.

In making this donation to Toronto, Mr. Rockefeller is desirous of recognizing especially the home of the discoverer of insulin and the place where insulin has been first developed. While, strictly speaking, the purpose of the gift is to make possible the treatment of a larger number of indigent diabetic sufferers, and to assist the teaching of physicians in general practice in the proper method of employing insulin in the treatment of this disease, the disposition of the monies received is left to the discretion of the Governing Board of each recipient Institution, to be used in the manner in which it can best further the treatment of the disease. The gift of \$5,000 to the University, is, it is understood, to be added to the Banting-Best Fund recently established by the Legislature and is to be placed at the disposal of Dr. Banting in furthering research work.

OSHIWA HOSPITAL TRAINING SCHOOL FOR NURSES

Oshawa citizens of all classes turned out en masse on June 28th, to attend the commencement exercises of Oshawa Hospital Training School for Nurses, held in King Street Methodist Church. This was the tenth graduation class.

Those who graduated this year were: Miss Lucy Wilson, Picton; Miss Addie McLaren, Port Perry; Miss Lillian Stokes, Uxbridge, and Miss Nettie Johnson, Cordover Mines. J. D. Storie, President of the Hospital Board of Directors, presided.

The speaker of the evening was Dr. G. F. W. Ross, Toronto, who addressed the graduation class, referring to the duties of the profession and the ideals to which nurses should adhere.

Prizes and diplomas were presented to the graduates. The James F. W. Ross scholarship for general proficiency was presented by Dr. Ross to Miss Lucy Wilson; the pin for neatness, given by Mrs. Charles Robson, was presented by Mrs. A. M. Irwin, to Miss Addie McLaren; the superintendent's prize for bandaging was presented by Major Frank Chappell to Miss Lucy Wilson; the prize for the highest standing in intermediate year was awarded to Miss Lillian Stokes. This latter prize was donated by Mrs. Frank Robson, and was presented by Major Chappell. Miss Stokes was also awarded the prize for the highest standing in surgical technique, which was donated and presented by Dr. F. J. Rundle. Miss Johnson was awarded the prize for the highest standing in dietetics, which prize was presented by Major Chappell and donated by Mrs. Robert Williams. The prize for the highest standing in practical nursing was presented by Major Chappell to Miss Johnson, the prize being given by Mrs. J. D. Storie. Miss Stokes was awarded the prize given by Dr. T. W. G. McKay for the highest standing in obstetrical work. This prize was presented by Dr. F. L. Henry.

The auditorium was taxed to capacity with citizens who witnessed the exercises with intense interest. The musical programme was of a high order, H. C. Trenner, organist, and

choirmaster of King Street Church, presiding at the piano. The class was somewhat smaller this year than usual, but it is expected that a large number will graduate next year. Following the exercises a reception was held for the nurses, when they received the congratulations of their friends.

HOSPITAL DAMAGED

Damage to the extent of about \$1,000 was done to the Niagara Falls General Hospital on June 27th by fire and water. None of the patients were in danger.

DR. A. E. ROSS, M.P., RESIGNS

Dr. A. E. Ross, M.P., for Kingston, who has been superintendent of the Kingston General Hospital for several years, has resigned that position in order to take up private practice. Dr. Ross tendered his resignation both before and after his election, but the Governors prevailed on him to stay.

FORTY-FOUR NURSES QUALIFY FOR PUBLIC HEALTH DIPLOMAS

Examination results of the Department of Public Health Nursing were announced on May 11th. The following candidates are eligible for the diploma in public health nursing:

Miss A. G. Armstrong, Mrs. M. Aspinall, Misses H. P. Barnett, B. A. Bloy, M. H. Barnett, E. A. Cale, M. M. Campbell, E. M. Christie, E. M. Glendenning, Mrs. J. F. Clissold, Misses M. D. Coatsworth, I. Coyle, L. L. Douglas, M. Duffield, L. J. Dyer, E. Ecclestone, J. Elliott, E. E. Fraser, E. Fry, H. B. Gardner, C. E. Greenwood, M. Grieves, M. E. Haszard, Mrs. A. H. Haygarth, Misses H. M. Long, E. A. Luxon, M. L. McCrohan, M. M. MacMillan, M. E. Mullen, S. E. Murphy, M. S. Proctor, M. I. Ririe, R. E. Sanders, M. Shackleton, V. R. Shipman, M. V. N. Sinclair, E. Sutton, F. Taylor, M. A. Twiddy, K. M. Van Allen, E. J. Walker, M. G. Wilson, M. L. Wilson, D. M. Wright.

FIRE AT ST. ANN HOSPITAL FOR THE INSANE

Acting like soldiers on parade, and offering not the least trouble, some 250 male inmates of the St. Ann hospital for the insane at Baie St. Paul, Que., were marched out of the building at two o'clock on May 11th when the north wing of the institution in which they were located was completely destroyed by fire involving a material loss of \$150,000.

The destroyed building, which was of brick construction, five storeys high, was erected three years ago.

It was operated by Les Petites Soeurs Franciscanes de Marie.

The fire was discovered by one of the inmates, who, in raising the alarm shouted at the top of his voice: "I am burning, sister, I am burning."

The sixteen sisters who have charge of the wing rushed into their clothing and proceeded to release the patients and muster them out. The flames spread rapidly and the menace of being hemmed in and cut off was great, but not one of the patients gave trouble. The fire seemed to breed in them a spirit of docility that helped the sisters in clearing the building. Some of the patients seemed to develop remarkable intuitive qualities and performed heroic acts of rescue.

The patients were marched downstairs to the first floor, given clothing and immediately afterwards were conducted outside and into other sections of the hospital not affected by the fire.

Though the patients were all mental defectives and ranged in age from three years to seventy-five, not a single casualty occurred.

This was attributed as much to the fine behavior of the vast majority of the patients as to the heroic efforts of the sisters.

TORONTO EAST GENERAL HOSPITAL ASSOCIATION

General feeling on the part of residents of East Toronto that hospital facilities more commensurate with its population should be provided in that section of the city, found ex-

pression on May 10th at a public meeting in Riverdale Collegiate Institute. Upon the motion of Isaac Pimblett and L. W. Trull, a resolution was adopted calling for the organization of a body to be known as the Toronto East General Hospital Association.

The resolution further authorized the appointment of a board of trustees to assume the responsibility for the administration of the funds secured and the details involved in the erection of the hospital. It also recommended the holding of a tag day for campaign purposes.

Dr. S. W. Plewes quoted statistics to show that Toronto did not compare favorably with other cities of Ontario, in the matter of hospital accommodation. In the number of beds in hospitals per thousand of population, he gave the following comparison: Kingston, 19.4; London, 14.8; Guelph, 9.9; Hamilton, 7.3; Toronto, 4.6. Hospital accommodation was the same now, he said, as in 1913, though the population had increased by 83,000 in that time.

Dr. E. A. McDonald said that there were not sufficient emergency beds in the Toronto hospitals to cope with a sudden epidemic or catastrophe. Many lives in the east end had been lost during the influenza epidemic of 1918, he said, because they could not be admitted to the hospitals in time. Of the 2,283 hospital beds in Toronto, 2,105 were filled as a general rule. He believed that the sum of \$100,000, left for such a purpose by the late William Hill would serve as the nucleus for the fund toward a new hospital.

Rev. Father M. Cline commented upon the population east of the Don, approaching 150,000, and said that a city of that size lacking a hospital would be considered behind the times. Frank Johnston, while in favor of a hospital, thought that it should be built by the city at large and the City Council be approached in the matter.

Riverdale Salvation Army Band was in attendance. Controller W. W. Hiltz presided.

MANY NURSES GRADUATE FROM ST. MICHAEL'S HOSPITAL

Thirty-one nurses received their diplomas at the recent graduation exercises of St. Michael's Hospital, Toronto, held at the Nurses' Residence. Dr. Gideon Silverthorn presided, and the speakers were: Dr. Magner, Dr. Harris McPhedran, Rev. Dr. O'Leary and Rev. Father Cline. Miss Dorothy James, Ottawa, was awarded the scholarship presented by the Hospital Women's Auxiliary for the highest standing in final year examinations, which provides for a post-graduate public health course at the University of Toronto.

The list of graduates is as follows: Hazel Ogilvie, Toronto; Christina Claremont, Gravenhurst; Mary Nealon, Toronto; Roselle Grogan, Toronto; Audrey Kearns, Toronto; Frances McVean, Malton; Mary Brown, Toronto; Edna Overend, Orillia; Irene McGurk, Toronto; Irene LeBlanc, Richibucto, N.B.; Marie Barry, Regina; Marion Harrison, Toronto; Elizabeth Crowley, Stratford; Elizabeth Seeney, Dublin, Ont.; Anna Creede, Owen Sound; Frances Hughes, Toronto; Maud Szammers, Toronto; Dorothy James, Ottawa; Mary Hanley, Kitchener; Maud Lawlor, Hawkestone; Maisie Young, Sudbury; Irene LeGree, Toronto; Marie Melody, Hamilton; Helen McGeough, Toronto; Edna Dias, Sydney, N.B.; Edna Rosar, Toronto; Mary McQuillen, Toronto; Pauline Burns, Lindsay; Helen O'Meara, Ottawa; Esther Collins, Peterboro'; Mary Hawkins, Tweed.

NEW MEASLES HOSPITAL

At its regular meeting on May 10th the Board of Health of Toronto decided to recommend to City Council that the city architect be instructed to prepare plans for a new measles hospital, to be erected adjacent to the Isolation Hospital, just east of the Don, north of Gerrard street. Council will also be informed that, owing to its delay in dealing with this matter the last time the board made a somewhat similar recommendation, it has become necessary to sign another lease on the private house on Selby Street, which is now being used as a measles hospital.

Items

KING LAUDS FINE GIFT TO MEDICAL SCIENCE

King George and Queen Mary, surrounded by British medical scientists in academic robes, on May 31st, laid the corner-stones of the hospital building being added to the University College Hospital and London University groups, as a result of the £1,250,000 gift from the Rockefeller Foundation.

The improvements are expected to make London hospitals among the finest equipped in the world, and allow the inauguration of an important experiment in the "unit" system of medical education, whereby the different wards are assigned to directors, who are not allowed to have private practices, but must devote their whole time to their students.

The "magnificent generosity" which makes this possible was warmly commended by the King in his speech today.

"It has been said that science knows no frontiers," he said, "and indeed the declared purpose of the trustees is to promote the well-being of mankind throughout the world. That they should have selected the University of London to receive this princely endowment is not merely a high and well-deserved compliment, and the creation of yet another tie of sympathy and friendship which links us with the United States, but it is also evidence and declaration of their conviction that the progress of science and the welfare of mankind is not delimited by national or racial boundaries, and that the work done here in London for the relief of human suffering, the improvement of medical education and the advance of science, is of service to the whole world."

DIETETIC NEWS

The sixth annual convention of the American Dietetic Association will be held in Indianapolis, Indiana, at Hotel Claypool, on October 15th, 16th, and 17th, 1923. The Canadian members of this association are:—

Caroline Burns, Toronto General Hospital, Toronto; Dorothy Chown, Sunnyside Hospital, Kingston; Olive Cruikshank,

MacDonald Institute, Guelph; Elsie Fearman, 332 Caroline St., Hamilton; Frances Hansford, 1175 Haro St., Vancouver, B.C.; Evelyn Hickman, 157 Bloor St. W., Toronto, Ont.; Margaret Hopper, General Hospital, Hamilton; Edith W. Jenkins, Montreal General Hospital, Montreal; Esther Kinney, General Hospital, Vancouver, B.C.; Annie L. Laird, Toronto University, Toronto, Ont. Aleda Lamminaw, Provincial School of Agriculture, Olds, Alberta; Robena Montgomery, Sherbrooke Hospital, Sherbrooke, Que.; Minnie Nickell, Ontario Military Hospital, Kingston; Mabel Parkin, Winnipeg General Hospital, Winnipeg; Maude A. Perry, Montreal General Hospital, Montreal; Y. M. Robbeck, Calydon Sanitarium Ltd., Gravenhurst, Ont.; Violet Ryley, Bethany, Ont.; Elizabeth Sherwood, Daly Building, Ottawa, Ont.; Jennie Sparling, Brandon General Hospital, Brandon, Man.

Hospitals in Canada training pupil dietitians are:

General Public, St. John, N.B., Two; Montreal General, Montreal, P.Q., Two; Hamilton General, Hamilton, Ont., One; Sick Children's Hospital, Toronto, Ont., Two; Toronto General, Toronto, Ont.; Winnipeg General, Winnipeg, Manitoba, Two; Calgary General, Calgary, Alberta, Two; Vancouver General, Vancouver, B.C., Two.

Book Reviews

Environment and Resistance in Tuberculosis. A Presentation of the Nature of Environment and Resistance and their relation to the Pathology, Diagnosis, Symptoms and Treatment of Tuberculosis, by Allen K. Krause. Baltimore: The Williams & Wilkins Co. Price \$1.50 in the United States, Canada, Mexico and Cuba; \$1.60 in all other countries.

Discusses the protective reaction by which the tissues seek to hem in and wall off the first tubercle bacilli that enter the body; also the local conditions through which the body resists the development of tuberculosis.

Constitutional symptoms are the best indicator and guide of activity, and generally illumine the indefinite and shadowy line between the actual and potential patient.

Patients suffering incipiently from marked constitutional symptoms often feel better after bacilli appear in the sputum — nature having applied the prime surgical procedure of more or less evacuating the disease.

The tubercle formation and the lymphatic system are the barriers of defence. Then also, the way the tissues react determines in no small measure fibrosis, caseation and repair, e.g., resistance.

The Medical Clinics of North America. Published bi-monthly
W. B. Saunders Company: Philadelphia and London.

Of great interest is Engelbach's well-illustrated article on Endocrine Adiposity, in the July issue; Tierney's on Precocious Puberty. Soper's contribution on Dyspepsia will be of especial interest to the general practitioner, as well as Veeders' on Whole Buttermilk in Infant Feeding Over Long Periods. In the Ann Arbor number, (March), members of the staff of the Michigan State General Hospital shine; Newburg writes on High Fat Diet in Treating Diabetes Mellitus; Warfield on Hodgkin's Disease; Wile on Treatment of Syphilis Contraindicated; Cabot on Those Painful Women. Chorea, Chronic Pancreatitis, Endocarditis, Madelung's Deformities, and other timely topics are instructively dealt with.

Tachycardia, Protein Restriction in Bright's Disease, The Meltzer-Lyon Test in Gall-Bladder Disease, The Management of Diphtheria, Influence of Hydrogen-Ion Concentration on Digestion, Bacterial Asthma in Children, and Diet in Certain Intestinal Conditions, are a few of the attractive subjects dealt with authoritatively in this excellent magazine for September, 1922.

The Surgical Clinics of North America, February, 1923,
Volume 3, Number 1. Philadelphia number. Published bi-monthly, W. B. Saunders Company, Philadelphia and London.

Deaver, Billings, Ashurst, Leslie Davis, Ebason, Frazier, Francis Grant, Houser, Jopson, Lipschutz, Muller, Raydin, Skellern and Turner Thomas present an up-to-date programme on such subjects as Hernia, Pituitary Disorders, Surgery of the Stomach, Hip Disease, Effects of Morbid Tonsils, Cholecystitis, and the Use of Air in the Diagnosis of Intra-cranial Lesions. Fine number.

THE DANGERS OF PROPINQUITY

Dr. Alfred Eddowes recently contributed to the *Veterinary Journal*:

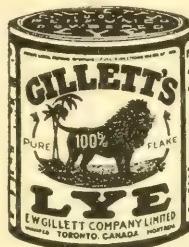
"Thirty years ago, when I was practising in the country, a young woman consulted me one evening for what was obviously ringworm on her cheek. A number of questions were put to her as to how she had caught it. She was a parlormaid and 'had nothing to do with children, ponies, cats, or calves.' I begged her to look round on going home and send me word if she noticed anything like it. Next morning a man stepped into my consulting room. Seeing a ringworm on the centre of his forehead I merely asked his name and told him I could guess all the rest. He was cowman to Mr. C. of S—Park; that he had not been at the job long—was, in fact, quite a novice—otherwise he would have had a cap ready to wear while milking. Further, that he was in love with the pretty parlourmaid, and no wonder. 'Doctor, you know too much, but it's all true,' was his reply, and I almost fancied myself a Sherlock Holmes!"

Hospital Superintendents

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Nurses and domestics to use

GILLETT'S PURE FLAKE LYE

for disinfecting sinks, closets and drains. It is also ideal for the cleansing of urinals and bed pans—in fact any vessel that requires disinfecting. Gillett's Flake Lye should always be used for scrubbing hospital bath tubs and operating room floors.

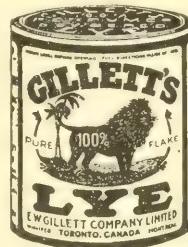


For cleansing and disinfecting, dissolve one tea-spoonful of Gillett's Lye in two gallons of water. The fine crystal flakes dissolve instantly in hot or cold water.

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Well made cocoa contains nothing that is harmful and much that is beneficial.

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THE ISABELLA PRIVATE HOSPITAL

Physicians will be interested to learn that a new, up-to-date Private Hospital has been opened at No. 94 Isabella Street, Toronto. The house is large, modern and solid-brick, beautifully furnished, every room having a most cheerful outlook. The street is quiet, being free from street cars, and therefore most suitable for convalescing patients. A graduate nurse is in charge and the rates are quite moderate.

BENGER'S FOOD—THE ADJUSTABLE DIET

Benger's Food is prepared with fresh cow's milk. It forms a dainty cream which becomes the easier of digestion the longer it is allowed to stand after mixing, the process being capable of arrestment at any time by simply bringing the mixture to the boil.

Patients ordinarily unable to digest milk can take this mixture satisfactorily, as the Benger's Food so softens the casein that when under the influence of the gastric juice it forms into minute flocculae instead of a heavy curd.

Benger's Food has a high nutrient value. The *Lancet* describes it as "Mr. Benger's admirable preparation."

THERAPEUTIC INDICATIONS OF BENZYL BENZOATE

Benzyl benzoate has marked vaso-dilator properties. It is therefore obviously indicated in spastic contraction of the arteries and just as obviously contra-indicated in arterio-sclerosis. In idiopathic or essential hypertension, high blood pressure without demonstrable renal involvement, the clinical results of benzyle benzoate medication are quite uniformly excellent. Even in the presence of nephritis the results have been gratifying; and repeated urinary examinations in such cases have failed to show any deleterious effects on the kidneys. Both systolic and diastolic b. p. readings show reduction, a purely symptomatic action according to Macht. When this has been accomplished by the use of full doses, the reduced pressure can be maintained by continuing the drug in small doses. Logically cases of arterio-sclerosis and of some renal affections must be eliminated since, in arterio-sclerosis, the calcified arteries are anatomically not capable of dilatation, and since in some cases of renal disease, reduction of the blood pressure may be harmful. Of this the physician will be the best judge as to the indication or contra-indication of this drug. Coincident with the lowered blood pressure there is an improvement in the patient's general condition; the precordial pain of hypertension is controlled; the anginal attacks, due as is generally supposed, to paroxysmal spasm of the coronary arteries, are materially relieved. One of the most convenient forms in which benzyl benzoate is obtainable is benzylets, soluble gelatin globules, each containing five (5) minimis benzyl benzoate in its purest state—Benzylets are made by the well-known Drug House, Sharp & Dolme, of Baltimore and New York.



*Exterior and Interior views
of Royal Alexandra Hospi-
tal, Edmonton, Alta., floor-
ed with Dominion Battle-
ship Linoleum.*



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Dominion Battleship Linoleum was installed in the Royal Alexandra Hospital, Edmonton, Alberta, because it possesses those qualities that are absolutely essential to the patients' welfare and the efficiency of the staff.

Its springy, resilient walking surface deadens all sound of footsteps; beds are easily moved over it and it is comfortable and restful to walk on. While highly germicidal and sanitary, Dominion Battleship Linoleum resists the heaviest traffic indefinitely, without showing signs of wear.

Dominion Battleship Linoleum

When properly applied with waterproof cement becomes a permanent floor, smooth and seamless. It cannot harbor dust or germs; it is easily kept clean and requires only an occasional waxing with a reliable floor wax to renew its original attractiveness.

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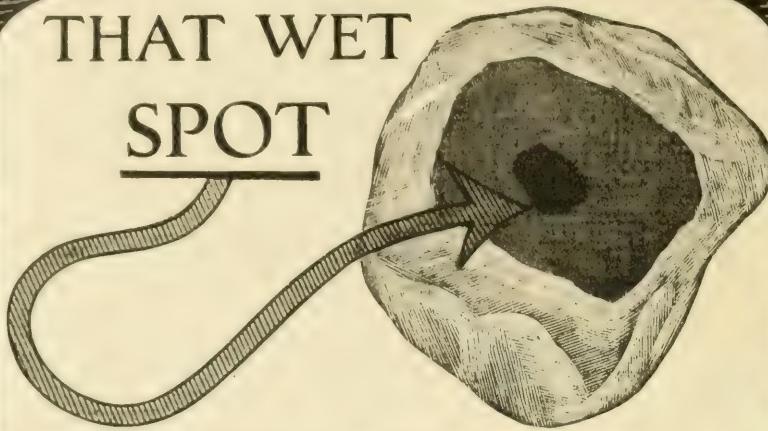
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Vol. XXIV

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No. 3

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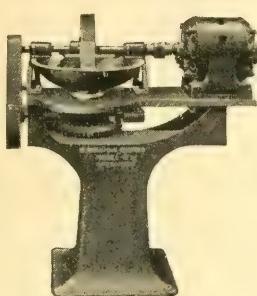
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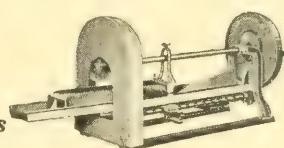
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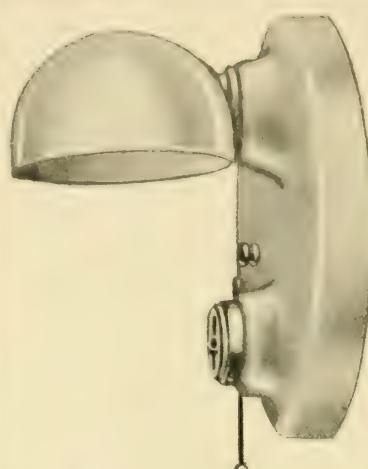
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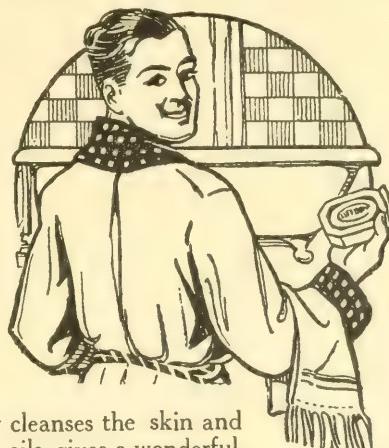
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Editorial

Medical Utopia

In 1516, Sir Thomas More published his famous "Utopia;" and in 1875 Sir B. W. Richardson published his "Hygeia," points out J. Walter Carr in a recent number of the *Lancet*, in an address in which he discusses some of the conditions which would call for consideration if the officials of the Ministry of Health were in a position to rule the country in a despotic manner as a benevolent autocracy:

Young couples desirous of marriage, after complete examination would be certificated as fitted in every way to propagate the race; and would receive detailed instruction in all matters of sex function and hygiene.

Those who fail to pass the required examination would be refrained from marriage and further from entering into irregular unions and begetting subnormal children. Should such illegal occurrences become common all ineligible adolescents might be

sterilized at puberty. This operation might also be performed later, on such as after marriage became unfit.

Following pregnancy, the young wife is allotted to the nearest antenatal clinic and her unborn babe brought within the grip of the authorities which shall not be relaxed until at a ripe old age his mortal remains are disposed of —*cito, tuto et jocunde*—in a municipal crematorium. The mother will be examined at intervals during the puerperium, forbidden to work and given suitable food. Parturition must not be allowed amid the unhealthy surroundings of the home, but at a municipal maternity clinic possibly several weeks before term, to save the patient from the discomforts of this period.

The birth will be duly notified, and the mother instructed on breast feeding. She will then be referred weekly to the infant welfare clinic for weighing, examination and superintendence of feeding. She is then handed over to the school Medical Officer. Meantime, if any illness develops she is transferred to the treatment clinic.

When shall the young parents again venture on the responsibility of parenthood? And how many children should they beget? Some still agree with the biblical injunction “to be fruitful and multiply” and have as many children as possible. A tenth or twelfth child may be a Shakespeare, Newton, or Pasteur. Others may hold, with the “Gloomy Dean,” that “over-population is the result of a very low standard of civilization,” and that “families are restricted whenever the parents have social ambitions

and a standard of comfort." In Vienna recently, due to hard times, steps were taken to encourage contraception amongst women whose circumstances, after investigation, justified their wish not to have children.

In the future Utopia birth restriction will be practised. What directions will the medical profession give that will not damage health or diminish pleasure? Absolute continence? Those who suggest continence are elders who have likely forgotten they ever had sex instincts, or ecclesiastically-minded celibates. Such inhibitions would only provide work for the unemployed psycho-therapists.

Medical men and medical women might state, under the seal of anonymity, by what form of restriction they are able to beget such small families.

As to the appendix, when it is realized that no one is the worse for its removal, and the dangers of operation are practically *nil*, the conviction is irresistibly forced upon us that it would be infinitely preferable in all cases to remove this organ in early childhood.

The colon must go, too. Metchnikoff held that "not only the rudimentary appendix and cecum, but the whole of the large intestine are superfluous, and their removal would be attended with happy results." Dr. Barclay Smith says the colon is "a useless encumbrance"; and Sir A. Keith's words are: "the opinion gains ground every year that the great bowel is a useless and dangerous structure." Such is the penalty man undergoes for assuming the erect posture. Until universal colectomy is performed, the U.S. must allow the Standard Oil to carry on and

John Bull must hang on to the Mesopotamian oil-fields.

In view of all the systemic troubles they cause—rheumatism, neuritis, arterio-sclerosis, etc., the tonsils and teeth must go early and completely. The risk is small, and see how much suffering humanity is saved.

Carr says it would be intensely interesting if reports could be obtained of all patients who in recent years have been rendered edentulous under medical and dental advice, as to the exact amount of benefit they have derived from the treatment. "One meets now and then with ungrateful patients who persistently avow that their rheumatism, their pains, their nervous or intestinal symptoms are not one whit better," since their loss of these organs.

As to vaccine treatment, the essayist pointed out that vaccines are now used for many diseases. Could they abolish the deaths in Great Britain from the infective respiratory diseases, the mortality rate would be reduced over 15 per cent. The vaccination protagonists would control these common and most fatal diseases by a well-devised blend of some half-dozen micro-organisms to produce an immunity, begun in infancy and continued through life!

As to eyes, if ophthalmologists are to be trusted, a really perfect pair of eyes is almost as exceptional as an absolutely sound set of teeth. Refractive errors should be corrected up to one-eighth of a diopter.

As to psycho-therapy: in future doubtless psycho-analysts will be attached to schools, colleges and

Courts of Justice. A very large number of trained Josephs and Daniels, up-to-date successors of the magicians, astrologers and soothsayers, specialists in the difficult task of interpreting dreams, will be employed.

Speaking of pulmonary tuberculosis the satirical orator enquires: "What reasonable probability is there that a man who in a particular environment has developed phthisis, will not relapse when, with lungs more or less extensively damaged, he returns to his old conditions of life, with diminished wage-earning capacity and consequently a severe handicap in the struggle for good food and good housing?"

The other change is in our present practice of doing our best to develop tuberculosis in children by allowing them to drink milk containing an unknown number of tubercle bacilli, and then with the anticipated result, of going to infinite trouble and expense to prolong the lives of those same children after they have been crippled, deformed, diseased, maimed and scarred by tuberculous disease of bones, joints and glands.

Speaking of venereal disease, Dr. Carr says the young man at puberty will receive full instruction with regard to his sex organs, their functions, use and abuse. He will be taught that the only absolute safeguard against infection is continence. If this is impossible he will be taught the use of chemical prophylactics. He will carry his packet as he does his handkerchief. Police might be instructed to see that unmarried men always carried them after a certain hour daily.

"Now at last arises a hope for mankind of release from his bondage, for if in one important department of life men may transgress with a reasonable degree of immunity, why may not relief come equally in other directions?" The outlook is far-reaching, and yet the law has a disconcerting way of asserting itself. . . . "Whatsoever a man soweth that shall he also reap."

Referring to organotherapy, the essayist says that we are learning to appreciate the fact that when one gland suffers, all suffer; hence the introduction of polyglandular therapy . . . a recent pan-glandine preparation is said to contain eleven different organs of the body, reminding one of the elaborate therapeutic mixtures of our forefathers!

Such despotism under a medical autocracy would destroy our freedom. Entrust a group of individuals with power and they soon become unfit to use it.

Health depends first and foremost on obedience to law . . . and nothing which is morally wrong can be physically right. We need sufficient and suitable food, pure water, fresh air and adequate sleep, and enough exercise; but there are moral laws, disobedience to which is disastrous to health and life. How many are the victims of lust, drunkenness, covetousness, making haste to be rich, and so on!

There is a danger of dealing too much with secondary consequences rather than primary causes. There must be an intimate combination of socialism and individualism—harmonious co-operation in our schemes for adequate housing accommodation, good sanitation, pure water, fresh air, healthful shops, no

excessive hours of work, efficient hospitals, and a wage enough to enable a man to provide for himself and family, food, warmth, clothing and recreation. While these are essential, they are entirely insufficient without the determination on the part of each man and woman to obey the great moral and physical laws.

For the attainment of ideal health and length of days both the man and his environment must be purified, uplifted and ennobled.

Let us hear the conclusion of the whole matter: "Fear God, and keep his commandments," that is: obey the moral and physical laws equally. Thus, and not by seeking short cuts to health, or by attempts to evade the results of law-breaking, can we hope to reach the goal of our ambition: a genuine medical Utopia.

Open Ether

Arthur Waters, of the Radcliffe Infirmary, uses a home-made ether apparatus. As a drop bottle he improvises with a small medicine bottle, a rubber cork, and a piece of glass tubing. We wonder if he has tried the ordinary cork with a wedge-shaped piece cut in its side.

Waters is averse to chloroform, as dangerous, and the clover inhaler is too often *hors de combat*.

He secures (1) a piece of thick white felt, five-eighths of an inch thick, measuring ten inches by six inches; (2) a duster or small towel; (3) a cir-

cular piece of ordinary white lint about a foot in diameter.

The sheet of felt is moulded round into a cylinder, and the edges carefully sewn together by a double row of stitches, the inner edges first, the outer edges last.

The sewing stops at a point about three-quarters of an inch from the bottom, and the square corners are rounded off. This notch fits over the patient's nose. At the opposite end the sewing is continued to the very top. The piece of lint is next used to form an accurately fitting and perfectly flat diaphragm across the cylinder about an inch or an inch and a half from the top. The centre point of the circular piece of lint is pushed down about three inches into the cylinder from the top, the edges uniformly arranged around the circumference, slightly pleated, and securely and evenly stitched to the top edge of the felt. The lint being now securely fixed, it is flattened out with the fingers, and a further row of stitches carried round through felt and lint lower down. Thus a flat diaphragm across the cylinder is formed. The edge of the lint is allowed to hang down outside all round.

Before use, the mask and small towel (folded like a scarf) are placed in a bowl of very hot water for about ten minutes and kept very hot. Two ounces of pure ether are next poured into the drop bottle.

Waters gives his patient (unless small) a hypodermic injection of one-twelfth grain of heroin and one-hundredth grain of atropine half an hour before the operation. This makes them pleasantly drowsy

and allays nervousness. He examines heart and lungs, with a few assuring words and then thoroughly applies vaseline to chin, lips and nose, explaining the reason therefor. The mask is then taken from the hot water, wrung out by hand, and placed lightly over the face and nose. The patient finds breathing the moist warm air pleasant; as a preliminary a few drops of cologne water or tincture of orange may be dropped on the mask. Two or three wisps of dry cotton wool are then placed on the diaphragm and on them a few drops of ether are let fall; the patient is told that the ether is being started and asked to breathe naturally. Very quickly he tolerates a more rapid flow of drops and as the wisps of cotton wool become saturated a few more may be added. The stream of drops should be continuous and directed in turn over each segment of the diaphragm.

When the patient begins to show signs of losing consciousness, the little towel folded in the shape of a scarf is wrung out, put under the chin, and held by the left hand up against the mask on either side of the face, obliterating any space between mask and skin through which too much air may be drawn in. The notch will fit the nose accurately and eyes and forehead are absolutely bare and easy of inspection.

As unconsciousness deepens the ether may be dropped more quickly and, in an average case, it will be found that when two ounces have been used the patient is just "under" and ready for the preliminaries of the operation.

When full anesthesia is established it is permissible to place an extra wisp or two of cotton wool on the diaphragm, use a little more ether and cover the top of the mask with a small sheet of wool, or fold over the edges of the lint, whereby the patient for a short time, gets less air and a stronger ether vapor. It is useful to be able to do this while you refill your drop bottle, or in case you want to deepen anesthesia quickly.

The most essential point in giving open ether is that the drug should be given constantly, uniformly and continuously.

The felt masks are best cleansed by careful washing, followed by a soak in one-fortieth carbolic. Too much boiling causes them to shrink and become hard. In any case they shrink, and may then be used for children.

For Americans in London

Those who are conversant with the work of the American hospital in Paris will appreciate the value of a similar institution in London. The former, the establishment of which was largely financed by one or two wealthy Americans, is marked as a place of architectural beauty. Its purpose is to render skilled medical service by American doctors to Americans visiting or resident in Paris. During the fateful years of the war it launched into extensive activities which placed it in the forefront of Red Cross work. Its large, generous, and continuous service will never be forgotten by the French people.

Now it is proposed to found a hospital along similar lines in London, to be staffed by American doctors and nurses, and to minister to the needs of the 12,000 or more American residents in Britain, as well as those of the large throng of American transients. At present the scheme is in its infancy; but a permanent committee has been formed consisting of representatives of all American and Anglo-American Societies to consider ways and means of promoting the project.

Several years ago an Anglo-American hospital venture was initiated in London largely for the purpose of furthering medical research. This object is now served by the recent Rockefeller Foundation gift to the London University Hospital, but it is considered that there is still need of a place where American citizens may be cared for, since the present system is very unsatisfactory.

The London hospitals are in financial straits and naturally they feel that the British have first call on their facilities, which are not ample to meet even their own requirements.

Consul General Skinner, who is heading the committee says that the hospital it is proposed to establish will likely not be as pretentious as the one in Paris, but it will be operated on the same plan. Patients are to pay if they can afford it; otherwise their treatment will be free. There seems to be no doubt that sufficient funds will be forthcoming to finance this desirable project at an early date.

Voluntary Hospitals

The British Voluntary System is in a state of transition.

The *Lancet* says the British Medical Association has elaborated a policy which includes the establishment of a special staff fund to be placed at the disposal of the medical staff of each voluntary hospital. And it is suggested that to this fund there should be passed a percentage of all sums received from or on behalf of patients (other than private patients) towards the hospital costs.

It appears, the *Lancet* states, that on this question opinion is sharply divided: at one extreme there is the whole-hearted supporter of the principle that all payments to the hospitals by and for patients (other than private) are payments towards all the services of the hospital, medical and ancillary. Such a one holds that there is no justification for exploiting the doctor in the case of a person who is able to contribute to the hospital charges. He considers that the principle should be carried to its logical conclusion, that all such contributions should be assessed in a percentage for the staff fund, and that only necessitous persons should receive gratuitous services from the medical staff. In his view the assessing of such percentages does not, nor need not, interfere with the voluntary principle of the hospital. At the other extreme is the man who desires to continue intact his gratuitous services at voluntary hospitals. He fears that by assenting to the proposition of a staff fund he will alter his status at the hospital—will become to some extent a paid

servant of the institution. Moreover, he is in doubt whether his acquiescence in the proposal may not lead to the ultimate abandonment of the voluntary principle in hospital management.

Between these two extremes, according to our contemporary, there are many shades of opinion. Thus most members of hospital staffs probably feel that the state and the municipality have no right to expect gratuitous treatment for patients for whom they are responsible. Others adopt the same attitude toward employers, approved societies, contributory schemes, and so on. Others, again, feel that a distinction should be drawn between maintenance and treatment and would only agree to contributions to staff funds where the payments by or for the patients exceeded the cost of maintenance.

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Editors:

ALEXANDER MACKAY, M.D., Inspector of Hospitals, Province of Ontario.

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Selected Articles



FLAT FOOT

CLARENCE L. STARR, M.B., F.A.C.S., PROFESSOR OF SURGERY,
UNIVERSITY OF TORONTO.

Any affection of the foot which interferes with comfortable function in whole or in part, is a serious disability to the average individual. Aside from injuries to the feet, the bare-footed peoples of the world, and to a proportional extent the sandal and moccasin-wearing peoples, are free from the great majority of the disabilities found among so-called civilized peoples. This suggests that the modern clothing of the feet is responsible for the bulk of foot trouble as seen in the daily contact with patients complaining of disabilities so great as to interfere with comfortable function. It is also responsible for a diminution in function to a greater or less extent in the army of non-complaining individuals, some of whom do not know what foot comfort is. The absence of foot constriction and the active life of these bare-footed peoples encourage a muscle development of leg and foot which is also a factor in maintaining good function, and is not seen in wearers of modern boots. The luxurious tendency of the age, with the advent of the automobile and other methods of transportation, tempts most individuals to ride where they might better walk, thus lessening their muscular development and increasing the bulk weight to be carried, and thereby other factors are added which are certainly responsible for loss of function. The development of the muscles of the foot and leg is possible to a wonderful degree by the active use of the feet, as in climbing and similar exercises, excellent examples of which are seen in some of the bare-footed races. That this development is possible in modern civilization is shown by the few cases of congenital absence of the hands, or similar defects, in children, which makes imperative the early use of the foot as a substitute for the hand. These children have so developed

the muscles of the feet that knitting, writing, fine sewing and wonderful dexterity generally are possible.

A study of the advertisements of the modern boots, especially those designed for women, will show at a glance that all attempts to clothe the foot comfortably have been abandoned in most cases. For not by the wildest stretch of the imagination can one feel that the modern boot has the slightest resemblance to the normal or undistorted foot. Until the public can be educated to the wisdom, from an economic standpoint as well as from the standpoint of comfort, of starting the child with a properly shod foot and following this into the periods of adolescence and manhood and womanhood, so long will our generation continue to suffer from distortions and disabilities with the consequent loss of economic usefulness. It is argued that designers and manufacturers do not make the proper sort of footwear, and therefore the public are compelled to buy what is manufactured. The answer is, that the manufacturers and retailers make and stock what the public demands, and if the public demands a proper shoe, and will buy no other, the manufacturers will soon supply it. The worst defects in shoes are the high heels with narrow weight-bearing base, and the narrow-pointed toes, especially if pointed in the middle of the boot. The essentials of a good boot are a straight inside, a square flat heel, and a sole wide enough at the ball to permit toe movement.

While a fairly large percentage of the cases of disability of the feet is due to flat foot, it is by no means the only condition existing, and yet in a great many instances as soon as a patient complains of the feet a diagnosis of "fallen arches" or flat foot is made on a most casual examination. The next procedure is to order, or permit the ordering of flat foot plates. A general statement may be made that for the most part these plates are useless for the purpose for which they are intended, and in a great many cases they are harmful.

ETIOLOGY.

In addition to faulty shoes there are three factors which predispose to the production of flat feet.

1. Excessive or faulty use, or both. Many individuals with ordinarily good feet suffer foot strain and flat foot under unusual use. Nurses on long hours of duty on hard floors,

policemen also on long hours of duty, bakers or butchers, who, in addition to being on their feet for long periods, often have to carry heavy weights, may all suffer from acute flat foot. Faulty use of the feet, especially in standing and walking, is also a predisposing factor. Most children are encouraged to turn their toes out when they walk. This habit is carried into later life and makes for a bad weight-bearing line—the centre of gravity falling over the scaphoid instead of being carried down the centre of the foot to the toes. Especial attention should be given to patients recovering from acute illness as they are likely to suffer severely from acute foot strain.

2. Overweight. Patients rapidly increasing their weight are apt to become flat footed when the foot structures usually carrying, say 120 pounds, are called upon to carry an additional 40 or 50 pounds.

3. Defective muscular development. From faulty nutrition or lack of proper exercise the muscles are not strong enough to stand the strain, and the superincumbent weight falls on the ligaments. These soon stretch and flat foot results.

SYMPTOMS AND SIGNS.

The flat foot has lost its normal contour, the inside of the foot is convex instead of concave from heel to ball. This is due to the abduction of the front part of the foot from the midtarsal joint. The arch on the inner side of the foot thus disappears and this inner side comes in contact with the floor. Varying degrees of deformity may be present, from a very slight pronation to a complete flattening. The gait loses all its elasticity and the flat-footed individual walks with toes turned out, bending the knees, and never getting a true heel and toe gait. The boots show the line of weight bearing, and wear off at the heel and sole on the inside edge, the shoe being "run over" toward the inside. The flexibility of the foot is lost to a greater or less extent, depending on the grade of the deformity, and may be so nearly lost as to produce a rigid foot. This rigidity is due to an accompanying arthritis, partly traumatic and partly toxic. It should be remembered that the faulty weight-bearing foot-producing strain on the tarsal articulations soon results in synovitis. The presence of infection in the tonsils, teeth, and so on, readily adds a toxic inflammation, and the feet lose motion from muscle spasm

and adhesion of joint surfaces. Pain is a fairly constant factor. It is not necessarily greatest in the severest deformities. It is most acute in early stages of breaking down of ligaments and in cases where there is an added toxemia, as every movement is painful. When the complete flattening has occurred, especially if associated with complete fusion and loss of motion, pain usually disappears.

DIAGNOSIS.

The appearance of the foot and the gait of the individual, together with the story of faulty weight-bearing told by the boot, usually render a diagnosis easy. A print of the sole of the foot which has been smeared with lampblack will show how much of the plantar surface comes in contact with the floor as compared with the imprint of the normal foot. If the contour of the foot is normal, the arch well up, the inside of the foot concave, the weight-bearing line true and the foot flexible, a diagnosis of flat foot is not justifiable, and some other cause of pain and disability must be sought.

TREATMENT.

It should be possible by a process of education as to proper footwear, method of walking and standing, and general hygiene, to prevent this distressing malady in future generations, and efforts along this line should be made by the medical profession.

A study of each case should determine the course of treatment indicated in such case. In early or incipient cases, especially in young individuals, it may be sufficient to see that they are properly shod and instructed in the way to walk with the feet parallel, so that a heel and toe gait is maintained. For a slightly more acute stage a wedge of 1-4 to 3-8 of an inch on the inside edge of the heel and sole may be added. These cases will also require muscular training of the weak muscles. Tip-toe exercise with heels apart, lifting the inner side of the foot and rolling over on the outside edge, walking a crack with the centre of the foot placed accurately on the line one foot in front of the other, picking up small objects with the toes or standing on a raised surface with the toes over the edge, clawing the toes downward, and similar exercises, will develop the defective muscles and restore the bal-

ance of the foot. These exercises should be done a minimum number of times at first, and increased each day until the maximum is reached.

Overweight should be corrected by proper diet, exercises, and so on.

Supports should be used only when for some reason, such as heart defects, these exercises cannot be carried out. When a support is recommended it should be made of material sufficiently rigid that it will not flatten out under pressure of the weight to be carried. Most of the arch supports purchased are made of German silver, and can be flattened out easily, and in a week they are completely flat. The support should be made over a cast of the corrected foot, and should be high enough on the inside to support the scaphoid. It should also be short enough to permit heel and ball of the foot to rest on the sole of the boot. No support should be applied in a rigid foot until the arch can be restored by manipulation or strapping with adhesive plaster. The completely rigid non-painful flat foot is probably best treated by leaving it alone.

—Exchange.

THE SYMPTOMS OF ACUTE OSTEOMYELITIS

D. E. ROBERTSON, M.D., F.A.C.S.

ASSOCIATE SURGEON, HOSPITAL FOR SICK CHILDREN, TORONTO.

Acute infectious osteomyelitis is most frequently seen, on admission to hospital, as a well advanced disease. The patient is extremely ill and the local condition is well advanced, and usually presents a large brawny swelling that is about to break. It may, indeed, have already broken, or it may have been incised and a wound remain from which discharges large quantities of pus. Pain is severe, and the patient is almost worn out with toxemia and pain. The involved extremity is carefully guarded from even the slightest movement. Frequently there are multiple lesions, and this adds greatly to the difficulties of the case.

Everyone has seen the cases of this disease that have survived the acute attack. They will recall the long convalescences, and the patients' tedious return to general health.

More tedious still is the cure of the local bone condition. This, with its discharging sinuses arising from bone involved throughout a wide extent, persists for years, and disabilities of a permanent nature result.

Is this disease one that, once begun, must produce always such extensive bone destruction? To answer this question one might assume that, inasmuch as the condition is a local septic infection, an early diagnosis might permit treatment that would limit the spread of the infection. In order, therefore, that the early symptoms might be studied, a review of the histories of acute septic bone infections has been undertaken.

There have been eighty-six cases of this disease in the Hospital for Sick Children since 1918. This is the only acute septic infection of the diaphysis that is described in any of the histories. This disease will be referred to here as Acute Septic Osteomyelitis, and will refer to those cases only where the infection is introduced into the bone by way of the blood. Infection occurring in compound fractures does not come under an acute septic osteomyelitis classification.

It was apparent in looking over the histories that the early symptoms were not always recorded, nor in all cases were the events leading up to the onset fully described. It was evident from the large majority of the histories that they described a disease that was peculiarly constant and definite in its symptoms. There were found to be present two predisposing factors that determined the attack. The first was injury—the second, infection.

INJURY.

The histories in twenty-eight cases recorded a definite history. The injury was in practically every case apparently unimportant. It was such as a child tripping or twisting an ankle, knee or hip, falling off a chair, or being thrown against a wall or floor and sustaining an injury in the region of a joint. The injury was sufficient to interfere with the function of the part and if the part concerned were a leg, a limp would result. This might be very transient, and last for an hour or so, or it might persist for a day or two. If the limp were to last for a day, the patient would be said to have sustained a "sprain." The recovery from this might be com-

plete, and a clear period intervene before the onset of the acute infection. Cases were described in which the patient reported for the primary injury, but this on examination was found not to be a fracture, and the patient was sent home only to return in a few days with an infection in the region of the injury. There were many histories that did not record an injury. In those cases it is very probable that in the severe illness that supervened, the memory of a slight injury was lost.

INFECTION.

It has been pointed out by various observers, and very recently by Phemister, that cases of acute osteomyelitis have a superficial skin lesion. This lesion may be the ordinary furuncle, but more frequently is an infected cut or wound. It would appear, therefore, that superficial lesions may infect the blood stream. It is a fact that most cases of acute septic osteomyelitis yield a positive blood culture in the early stages of the disease. The tonsils are also to be regarded with suspicion, and it is probable that the streptococcal infections find entry here. The age in this series is always under fifteen, as this is the age limit of the patients who are admitted to the Hospital for Sick Children.

The first subjective symptoms may be local or general. Acute osteomyelitis may occur in the presence of a general infection, and in all such infections in the young, one will not infrequently see a localization appear in a bone. This type is very serious in the immediate outlook, as death may supervene in a remarkably short time; it may be a matter of hours even. In this type of case the osteomyelitis plays a very minor rôle.

The local subjective symptoms stand out in no uncertain fashion. Pain is the prevailing feature, and it is continuous after its onset. The pain during the first few hours is not necessarily so severe as to prevent walking, if the disease be in the lower limb. It will, however, produce a limp, and for this reason may be considered as only a strain. This phase soon ends, and another of constitutional symptoms and a decided increase in pain ensues. The constitutional symptoms may be marked and may be ushered in with a chill, nausea and vomiting and high temperature. The pain by this time

(six to eight hours) is severe, and is interpreted as being in or at a joint. Without exception in this series of cases, where the history of early pain is available, the pain is referred to the neighbourhood of a joint. The histories demonstrate that there is no swelling, either of the joint outlines or tissue above or below. The joint is held flexed, and the limb guarded carefully and held perfectly still. On careful examination one may, if he gets the confidence of the patient, elicit movement of the joint, and this, together with the normal and unswollen contour of the joint, should be sufficient to rule out of one's deliberations the question of acute rheumatic fever. On palpation a very definite area of tenderness is found to exist, and this area is located always just above or just below the joint, and coincides closely with the epiphyseal line of the bone. Tenderness in the early stage is quite restricted, and is, on close examination, definite. The area over which one may elicit tenderness spreads in extent the longer the case is allowed to progress. Tenderness is the first positive sign one finds in an examination of acute osteomyelitis, and in order that one may know where to examine to best advantage, he must have an exact knowledge of the location of the epiphyseal lines of the various bones. Fortunately, these lines are not very difficult to remember, but if one does not care to burden his mind with this anatomical knowledge, he may have ready access to it in any text-book dealing with bone. Tenderness over these growing areas of bone is the most important sign of osteomyelitis, and it is at this stage that one should be able to conclude the diagnosis. The blood count at this time shows an increase in the white cells of the blood; the temperature is raised, and the pulse increased. The patient is beginning to suffer so much pain that sleep is difficult or impossible, and he has not yet concluded his first twenty-four hours of illness. There is no swelling as yet discernible, and it is at this point that the doctor may be led astray into a diagnosis of rheumatic fever. In the histories under review, the provisional diagnosis of the first two or three days is seldom mentioned. Where it is mentioned, it is rheumatic fever. The treatment to which these cases have been submitted, according to the records, is the local application of various drugs, salves, ointments, proprietary and otherwise, and the internal administration of salicylates.

Some cases have been submitted in the first twenty-four hours to X-ray examination. Unfortunately there is no abnormality to be seen at this stage, and the physician may, as a result, have a false security. One case in the series had five X-rays in seven days, and these were reported clear in so far as the bone was concerned. Once the provisional diagnosis is made of rheumatic fever, another point may rise that appears to substantiate it, and that is that pain appears in or about another joint. This appears to be corroborative evidence. It must be remembered that osteomyelitis is frequently multiple. The blood count does not give information that is positive in regard to a differential diagnosis, although an increase in the leucocytes is generally a marked feature.

After the first twenty-four hours, the symptoms are all more marked. The pain maintains its constant character, and sleep becomes impossible. The leg, or whatever part is affected, is guarded from any movement or jarring that might occur. The pain becomes so severe that the patient screams if he be touched. The temperature is high, with a rapid pulse and marked symptoms of intoxication. The blood culture is frequently found to yield a *staphylococcus aureus*.

After the first twenty-four hours, to the local sign of tenderness is added swelling. This is discernible in most cases in about twenty-four or thirty-six hours from the onset of the initial pain. The swelling at first is not marked, but as the days pass it advances steadily in extent. At first it is found to be just above or just below the joint, if the joint is a fairly accessible one. The common places for swelling to be first seen are the dorsum of the foot, due to infection of the astragalus, or just below the external or internal malleolus, due to infection of the os calcis, swelling just above either malleoli, due to infection of the tibia or fibula; swelling one-half inch below the head of the tibia, or just below the head of the fibula, and swelling externally or internally just above femoral condyles. The neck of femur is too deeply located to give obvious swelling, but swelling may occur over the great trochanter, or along the crest of the ileum, or on the perineum from infection of the pubis. In the upper extremity it may be seen over the scapula, most frequently at the tip of the acromion process, swelling of the shoulder over the neck

of the humerus, swelling just over the condyles of the humerus, swelling over the olecranon, swelling at wrist over lower end of radius or ulna, and in the carpal and metacarpal bones. The swelling occurs exactly over the area that first experienced tenderness, and as the swelling grows in extent, it is found to progress *away* from the joint, but as it reaches a size that is causing marked enlargement of the limb, the joint begins to show some enlargement, and the synovial sac becomes outlined. This may be due to a simple local back pressure of venous return, or it may become a septic arthritis.

When the patient is first seen in this stage of local enlargement of the thigh, the case may simulate a cellulitis, but one must beware of the suspicious location of the swelling, together with the extreme pain that is manifest. The swelling increases to such an extent that it "points" after a period of two or three weeks, and eventually, if left undisturbed, discharges of itself. The violence of the constitutional reaction, in those cases that recover, subsides after the first ten days, and if left without surgical intervention they, after their abscess is discharged, make a slow recovery in their general condition, to a condition close to normal. Locally the wounds granulate, but sinuses persist, out of which now and then are discharged pieces of dead bone of varying size. This condition may persist for years.

The diagnosis of an infection of the neck of the femur presents great difficulties. The upper epiphysis lies within the capsule of the hip joint, and is therefore almost inaccessible to manual examination. The hip joint is splinted, and shows the signs of an acute hip. It may be necessary to endeavour to aspirate the joint cavity. If the joint fluid is clear, and one is confident there is an infection in the neck of the bone, he should operate upon it. If he does not interfere early, a septic arthritis is produced, and the head of the femur is separated and becomes a sequestrum.

The following is a typical history: Previous to one month ago, the boy was perfectly well. On September 8th, boy came home from school complaining of pain in left ankle; said it felt as though he had sprained it. Later in the evening he complained of headache, and said he felt chilly; he became very feverish after going to bed and did not sleep for pain. On the following day the boy was sick at the stomach and

vomited. The pain in left ankle increased and the lad could not put weight on his foot; the ankle looked normal.

September 10th: Began to complain of pain in the right ankle as well, but constitutional disturbance less.

Sunday, September 11th: Both legs began to swell, especially the right, both quite hot and red. Patient was very feverish, and would not attempt to put weight on either limb; very tender to touch. Seen by doctor. Diagnosis: rheumatic fever, and put on treatment.

For next week patient was quite delirious, and legs swollen and painful. About September 20th mother says two yellow blisters appeared on anterior surface of right leg about half way down. When hand was rubbed over these areas, it gave the impression of a hole being beneath (about one inch across). Rubbed with camphorated oil, and dressed with absorbent. Boy complained a great deal of pain, and on dressing being removed, there was free discharge of pus from right leg. Abscess found two or three days later on left leg, and began to discharge. Rheumatic abscesses seen by doctor every second day—hot applications. Abscess also appeared on left ankle, and was opened. Abscess formed on knee was opened. Slight discharge.

Came to hospital in thirty days. Right leg—ankle very swollen, bluish in colour, extremely tender, and joint seems disorganized, abnormal motility in almost every direction. Swelling most pronounced over internal malleolus, and here there is fluctuation. Over external malleolus, three sinuses. Sinus seems thickened, and the leg is very tender. Bare bone may be felt through both sinuses.

Left Leg: The left ankle is also swollen and purplish in colour, most marked over the malleolar region. There does not seem to be so much destruction of the left ankle joint. Over left shin, three discharging sinuses. Upper sinus in region of tibial tuberosity. Upper epiphysis is quite loose, and apparently partially detached from the shaft. Knee is not involved.

The diagnosis of acute osteomyelitis is extremely urgent. The symptoms and signs are clear-cut and obvious. The preceding history relates a sprain, or a slight injury to a growing bone. Injury is done the growing line of bone because it is not yet rigid, and it is the spot where the stress is taken

up, and damage results. Co-existent with the pain, or injury, there may be a superficial infection, or a sore throat. One should view with alarm the co-existence of these factors—infestation and injury—and would be well advised to take a child off his feet for the time being. The disease having begun, the diagnosis depends upon general reaction and local tenderness. This tenderness is in the direct location of an epiphyseal line. These are the only points one requires for the diagnosis. If one waits until the condition becomes full-blown, they have caused that patient agonies that could have been cut short; they have rendered a condition that might have been cured in two or three weeks, one that will take years to cure.

The public require education in the seriousness of this condition. This series of cases demonstrates that about thirty per cent. of the cases do not consult a doctor during the first four days or more.—*Exchange*.

MRS. AUGUST BELMONT IS DONOR OF PICTURE OF FLORENCE NIGHTINGALE*

There has recently been presented by Mrs. August Belmont to the Nursing Service section of the Museum at National Headquarters, a very rare old engraving of Florence Nightingale.

Judging by the list of portraits given by her biographer, Sir Edward Cook, who had all records at hand, the picture is an elaboration from the sketch by Miss Hillary Bonham Carter, which was first published November 28, 1854, and shows Miss Nightingale seated on a piazza at Scutari, reading a book. In her hair there is a white rose, and upon her neck, a cross; while beyond the Straits, there lies Constantinople in the distance, with its towers and minarets.

This is one of the most famous as well as one of the most appealing pictures of the heroine of Scutari in existence, and perhaps more than any other, it portrays the qualities of character which won for her at the time the sobriquet, "Angel

*Half-tone of engraving loaned by *The Red Cross Courier*.

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Florence Nightingale

of the Crimea." It will be hung in the Nursing Service Exhibit, which is located in the South transept on the first floor of the main building.

Mrs. August Belmont was one of those who originated the idea of the Red Cross Museum, and since its development has been one of the most active and enthusiastic members of the Museum Committee.

BISMUTH PASTE IN WAR SURGERY

Emil G. Beck (*Annals of Surgery*, April, 1918), summarizes as follows, regarding this paste: The methods of primary sterilization by means of flushings with hypertonic solutions should be thoroughly tested to determine their effectiveness without the additional use of pastes. The radical excision of infected tissues, as now practised in the war hospitals, should be adhered to, as a means of preventing chronic suppuration. In those cases in which early sterilization was not obtainable, and the wounds persist in suppurating, the bismuth paste injection or similar formulæ should be employed before another radical operation was resorted to. Correct technic in employing the paste was essential if satisfactory results were to be obtained; it and similar formulæ were applicable in chronic suppurations resulting from war wounds, as well as in those due to chronic infectious diseases. In cases in which the bismuth paste treatment was not effective, the sutureless skin sliding operation should be employed, since with this method we were able to clear up nearly all of these apparently hopeless cases.

THE STANDARDIZATION OF RURAL HOSPITALS

Dr. Isaac S. Stone, of Washington, D.C., is in favor of bringing the standard of all hospitals, whether large or small, up to that point which would afford the best service to the public and which would require the best medical and surgical training of the staff. Sufficient information had been collected to show the number of poorly equipped hospitals in perhaps all parts of the country in towns and rural districts.

Many of these were but little better than boarding houses, without the essential equipment of house staff or laboratory, or indeed anything which justified the name of hospital. He suggested that all hospitals should be inspected by the health officer or commissioner of health, whether they were public or private institutions, and in case they were found up to the standard of requirement they should be duly licensed and required to send in a full report of the treatment of all cases during each year. Dr Stone also favored State aid to rural hospitals when necessary, to provide hospital relief in country or remote outlying districts. Especial attention was given to consideration of rural hospitals as social service centres and for the care of obstetrical patients whose homes were remotely situated or who were unable to obtain competent professional attendance.—*Selected.*

McCRAE'S MONUMENT

The Imperial Grave Committee have finally accepted the plan for a memorial to the late Col. John McCrae, C.A.M.C., in Wimereux Cemetery, France, for which funds have been subscribed by the Canadian Clubs of Canada. The suggested memorial is in the form of a stone seat at the entrance to the cemetery, at one side of which there is to be a house of records and at the other a shelter, both handsome structures. On the seat will be inscribed a verse from Colonel McCrae's poem "In Flanders Fields."

CYSTIN CALCULI: A COMPLEX SURGICAL PROBLEM

C. E. Tennant, Denver (*Journal A. M. A.*, Feb. 3rd, 1923), reports the case of a girl, aged 21, who had symptoms of distress (pain) in the right side, and some pain on urination. Finally, she had an attack simulating appendicitis. A moderately acutely inflamed appendix was removed, as well as twelve stones from the right ureter. A stone was also found in the right kidney. Later, roentgenograms of both kidneys and ureters were made, one stone being found in the left kidney and two in the right, with both ureters negative. At subsequent operations, all these stones were removed.

OSLER'S HEART

Embalmed in a casket, the heart of the late Sir William Osler, famous physician, will be placed in the Osler library at McGill University, upon its arrival from England. The heart, as well as a medical library of several thousand volumes, were bequeathed to the university by the physician. Special quarters in the new building have been set aside for the gifts.

THE DOCTOR SOFIE A. NORDHOFF-JUNG CANCER RESEARCH PRIZE

Dr. Sofie A. Nordhoff-Jung, of Washington, District of Columbia, United States of America, has founded an annual prize of five hundred dollars, bearing the title of "The Sofie A. Nordhoff-Jung Cancer Research Prize." This prize is destined for the encouragement of researches in the etiology, prevention and treatment of cancer. It will be awarded by a commission, composed of members of the University of Munich, Bavaria, and be granted for the first time in December, of the year nineteen hundred and twenty-three. The commission consists of Professors Borst, Doederlein and Sauerbruch, with Professor von Romberg as chairman. This body is empowered to elect successors. The award will be made as a recognition of the most conspicuous work in the world literature, bearing on cancer research, done at a time antecedent to the allotment of the award. Though the prize will not be awarded on a competitive basis the commission invites all research workers in cancer to submit literature on this subject.

PHTHISIS

No single sign or symptom of phthisis is of prognostic value when considered alone, for all special tests have proved fallacious when applied in the individual case. A prognosis in phthisis can only be made by a careful analysis of the constitutional symptoms, and correlating them with the signs obtained by physical exploration of the chest and radiography. Of the symptoms having a prognostic significance, the pulse is the most important. A patient with a slow pulse has a very

good outlook; one with a persistently rapid pulse is in a serious condition. Even when the physical signs show but a slight, or even healed lesion, the prognosis is poor as long as there is permanent tachycardia, or an acceleration of the pulse rate on moderate exertion. Afebrile cases with slow pulse have the best outlook. Those with moderate elevation of temperature, which declines after rest for a few weeks, may improve. But patients with high, continuous, or hectic fever, uninfluenced by rest, have but few chances to recover. Subnormal temperature is sign of a good outlook as regards duration of life, but as regards regaining of efficiency, the chances are poor.

Persistent anorexia, and diarrhea due to tuberculosis, ulceration of the intestine, or amyloidosis, are of bad augur.

Hemoptysis, irrespective of its severity or duration, when occurring at the onset of the disease, has no influence on the prognosis.

The prognosis is better in uncomplicated cases of phthisis than in those with tuberculous or non-tuberculous complications. Pleurisy at the onset of the disease is of good augury; when occurring during the course of the disease, a pleural effusion may improve the prognosis, provided it is not tapped. Empyema, pneumothorax, pyopneumothorax, and laryngeal tuberculosis are grave complications. The prognosis is good in cases of phthisis occurring in patients with the following diseases: left sided cardiac lesions, gout, chronic rheumatism, atherosclerosis, chronic nephritis, bronchial asthma, pulmonary emphysema, chronic bronchitis, and tertiary syphilis. The last mentioned when occurring primarily in a phthisical patient aggravates the prognosis; both diseases are apt to run a vicious course.

Sears indicating osseous, articular, or glandular tuberculosis during childhood, when found in a phthisical patient, are favorable signs.—*Selected.*

CAPILLARY PERMEABILITY IN ANAPHYLAXIS

If the lungs of a dog previously sensitized to horse serum are perfused with Locke's solution, followed by Locke's solution containing from 0.25 to 1 per cent. of horse serum, these

reactions were observed by W. H. Mainwaring, D. C. Chileote and V. M. Hosepian, Sanford University, Cal. (*Journal A. M. A.*, Feb. 3rd, 1923): (a) a 75 per cent. reduction in the rate of perfusion flow; (b) noncollapse of the lungs when the tracheal clamp is released, and (c) the escape of large amounts of fluid from the trachea when this clamp is released. The authors believe that the increased capillary permeability thus demonstrated will ultimately be shown to be the dominant fundamental physiologic change in protein sensitization, to which all other anaphylactic reactions are secondary.

INSULIN

It is wise that the insulin committee is advising the profession that the administration of insulin is not a substitute for present dietetic methods of treatment of diabetes mellitus. Nor is its use indicated in all forms of the disease. Clinical investigation has shown that insulin is chiefly of value in cases of diabetes mellitus that cannot be adequately controlled by dietetic measures alone. When used in conjunction with proper dietetic treatment, it removes all symptoms of the disease, as long as the treatment is maintained. It is a specific in the treatment of diabetic acidosis and coma, formerly the cause of death in over fifty per cent. of the cases of diabetes mellitus. What the ultimate effects of the treatment on the course of the disease will be, time alone will tell. Unfortunately, the administration of insulin is not free from danger; an overdose is followed by very definite signs and symptoms demanding immediate treatment. The cause of these symptoms and their appropriate treatment has been found.

TEACHING PRACTITIONERS

In order to assist physicians, more particularly those having limited laboratory facilities available (1) in the selection of cases for insulin treatment; (2) in methods of administration of insulin; (3) to become familiar with the untoward effects, a course of two days' instruction in the treatment of effects of over dosage of insulin and the treatment of these

diabetes mellitus is offered by the University at the Toronto General Hospital. Physicians taking this course will be offered at cost a limited supply of insulin for the treatment of cases of diabetes mellitus under their charge. The course of instruction will be offered to twenty practitioners every two weeks. No fee is being charged.

Hospital News

NEW MAIN BUILDING AT GRAVENHURST FORMALLY OPENED

With His Honor Henry Cockshutt, lieutenant-governor, officiating, the new main building of the Hospital for Consumptives at Gravenhurst, Muskoka, was formerly opened on July 27th, marking a new era of efficiency and profitable operation in the history of the organization. During the short ceremony this fact was the outstanding feature, showing, as all the speakers declared, that the public-hearted spirit to help those afflicted in the province was never more sincere and praiseworthy. It was shown that the year under review has been the most active, and from many points the most successful in the history of the association.

The new building is considered second to none for the purpose it is to serve. It is a modern fireproof five-storey brick building erected on the grounds of the Muskoka Cottage Sanatorium. It contains 182 beds, which, with the accommodation already at the hospital, will provide for 400 patients. Situated as the new hospital is, in close proximity to the Muskoka Cottage Sanatorium, a large saving in maintenance is anticipated through the linking up of service between the two institutions. In addition to the main building there is a dining room, kitchen service buildings, a central heating plant, new waterworks and new and adequate fire fighting equipment. All these new buildings, with the exception of the main building, are so laid out and linked up as to make them available for the Muskoka Sanatorium as well as the Muskoka Hospital.

One of the outstanding features of the ceremony was the report that although the association has been required to face heavy deficits for several years, the tide had now changed and it is felt that this present year will make a more favorable showing. George A. Reid, secretary-treasurer, said the results have exceeded the most optimistic anticipations. Since the Muskoka Hospital was opened it has shown an annual deficit in operating account, he said, and now, for the first time, a small surplus on the year's transactions is shown, as also for the Queen Mary Hospital. The Toronto Hospital for Consumptives, for which no special appeal has been made, shows an excess expenditure over receipts of \$5,510, but comparison of this with last year's deficit of \$40,828, and the heavy deficits of former years, shows a great improvement. The Muskoka Cottage Sanatorium, which has shown a small surplus for the past few years, this year has a deficit of a thousand dollars, accounted for by the unsettled conditions existing since the fire and the applying of much of its accommodation to the Muskoka Hospital patients.

"Whilst the standard of service to our patients has been maintained the cost has steadily declined," declared Mr. Reid. "The average reduction for our public institutions at Muskoka and at Weston is \$4.55 per patient per week. With the continued close co-operation of our physicians-in-chief in watching expenditures I am hopeful of a still better showing for the coming year. During the period we have expended for maintenance the large sum of \$528,208. Against this we have received from government grants, municipal allowances and from patients themselves the sum of \$384,301 leaving a gross deficit of \$143,906, which shortage has been almost provided for through the voluntary gifts of generous friends totalling \$140,286."

Another feature of the reports was the good work of the Samaritan Club amongst the consumptive poor, making it possible for the wage-earners of many families to leave their homes and to seek the sanctuary of the hospitals in an endeavor to get better. It was pointed out that during the campaign last summer the ladies in the smaller towns throughout the province gave their services and carried out excellent work in many branches.

The debris of the big fire has practically been removed and the grounds are once again attractive. Half of the administration building has been rebuilt and is now in use. The first floor contains the professional offices, examining rooms, dispensary, and X-ray rooms, as before, while on the second storey are the bedrooms for the medical staff, as well as a large dining room for the physicians and nurses.

HOSPITAL BOARD HEAD GIVEN TWELFTH TERM

For the twelfth consecutive term, T. H. Pratt was appointed chairman of the Board of Hospital Governors at the annual meeting held on July 25th. His colleagues on the board paid tribute to Mr. Pratt's many years of useful service and felt that the hospital was fortunate in having a man of his calibre to administer its affairs. Mr. Pratt replied briefly. He said it had been a pleasure for him to have served in the way he had. It was also a great inspiration to public service to know that one's efforts were appreciated. All members of the board and the staff were reappointed without any changes.

A. C. GALBRAITH APPOINTED TO RESPONSIBLE POST AT WESTERN HOSPITAL

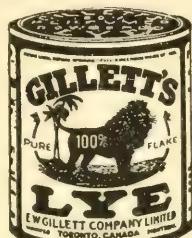
On the strength of fifteen years' experience as Quartermaster in the Canadian Army Medical Corps, A. C. Galbraith has been appointed Superintendent of the Western Hospital, duties commencing August 1. Mr. Galbraith leaves the position of accountant to the Huron and Erie Mortgage Corporation and the Canada Trust Company, which he has held from the time of the demobilization of the Canadian forces. He has been connected with these companies for the last thirteen years. One of the first Canadians to go overseas, Mr. Galbraith was sent to France with the C.A.M.C. in the First Contingent, August, 1914, and served in various hospitals in France and England. Later, he was appointed Supervising Quartermaster of Canadian Hospitals, attached to the Headquarters Staff, London, England, and he was in this capacity

until he was demobilized. His chief activities were connected with the organization and administration of hospitals, and in this work he gained a wide experience. He has been a member of the C.A.M.C. since 1908, and is a member of the Board of Trade.

NEW MEDICAL SUPERINTENDENT FOR VICTORIA HOSPITAL, LONDON

Dr. G. C. Clegg, of 534 Princess Avenue has been appointed medical superintendent of Victoria Hospital, in succession to T. H. Heard, who resigned some time ago, after more than twenty years' service. Dr. Clegg is a veteran of the great war, who since his return to Canada has held the position of assistant director of the D.S.C.R. at London. The change in management, it is stated, was brought about as the result of the investigation into hospital affairs being conducted by the Citizens' Research Bureau of Ottawa.

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ful, pleasing result is important, not only in the wards, but in reception rooms and lobbies, where friends and relatives wait, sometimes under depressing circumstances. The importance of ward lighting cannot be overestimated where every comfort of the patient is desired and where a lighting unit giving a soft, white light and arranged for local illumination near the beds in such a way that the patients' eyes are protected from strain, gives the best results. The Tallman Brass & Metal Limited, Hamilton, Ontario, large manufacturers of lighting fixtures, have given special consideration to hospital lighting and will freely send to those interested, catalogues, bulletins and full information concerning their patented, bras-colite, raylite, aglite and vitro-lite fittings recommended for this purpose. These fixtures are all a combination of white glass and white porcelain enamelled metal work, harmonizing perfectly with furnishings and other fittings and insuring absolute sanitation and cleanliness with the utmost lighting efficiency. The marvellous daylight quality of the light produced—its pure, clear, even distribution, soft warm light, without glare, secured by diffusion and reflection, make these units the most suitable and serviceable lighting for modern hospital purposes.

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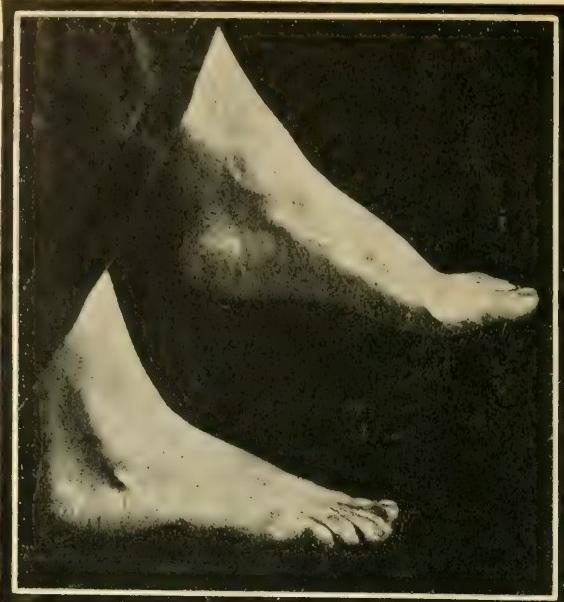
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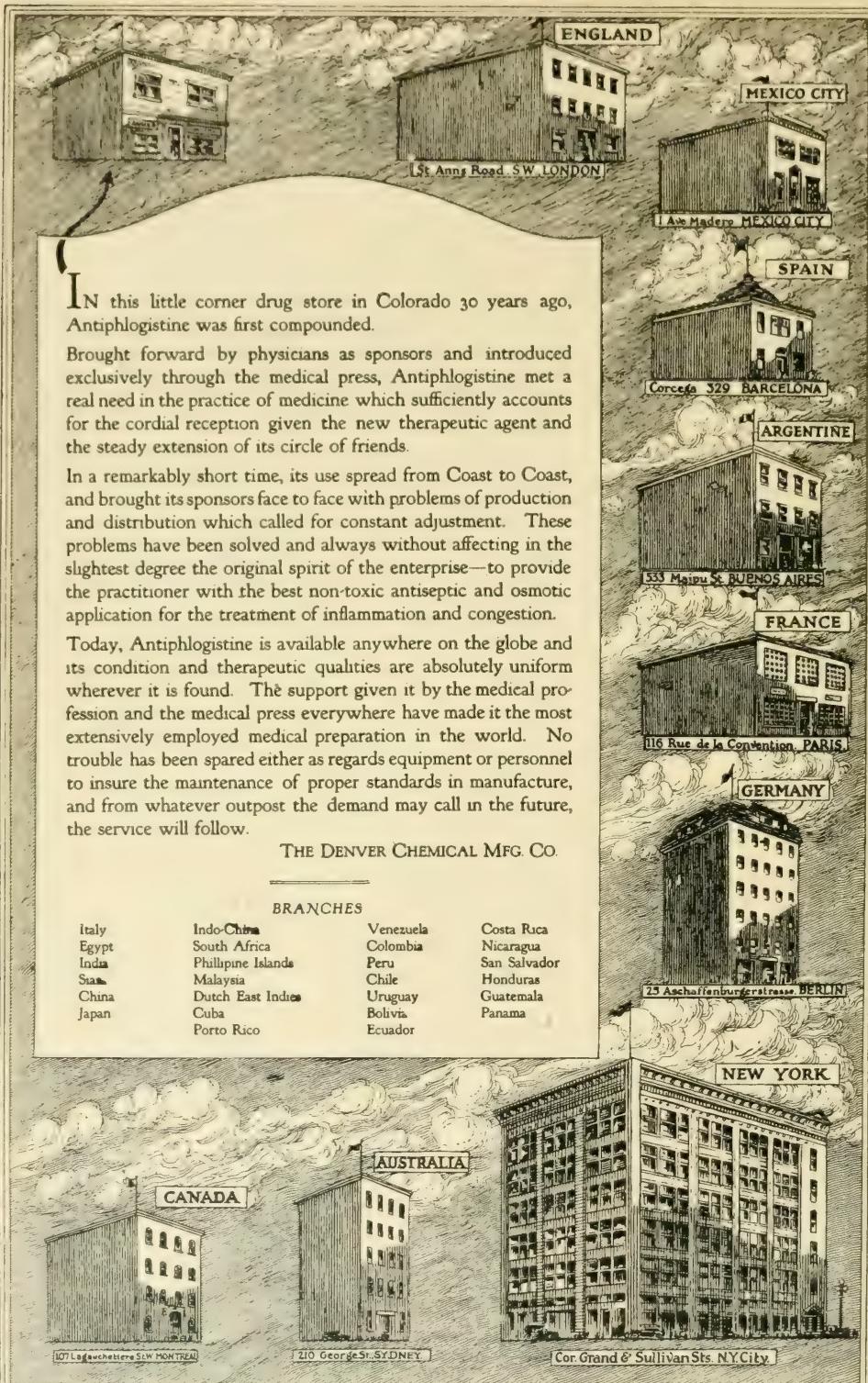
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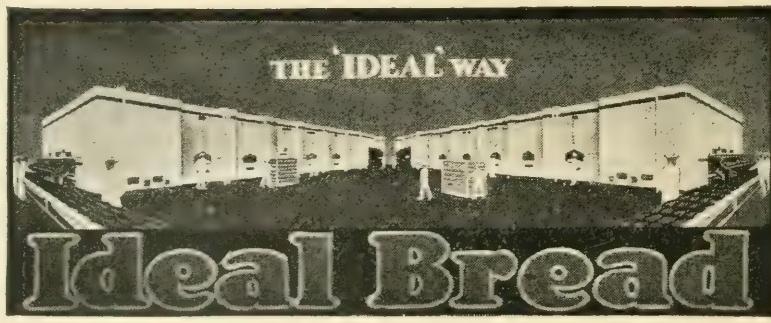
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Vol. XXIV

Toronto, October, 1923

No. 4

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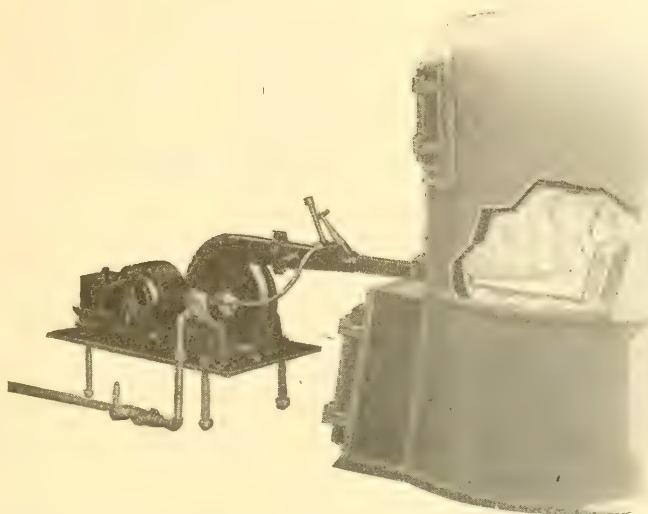
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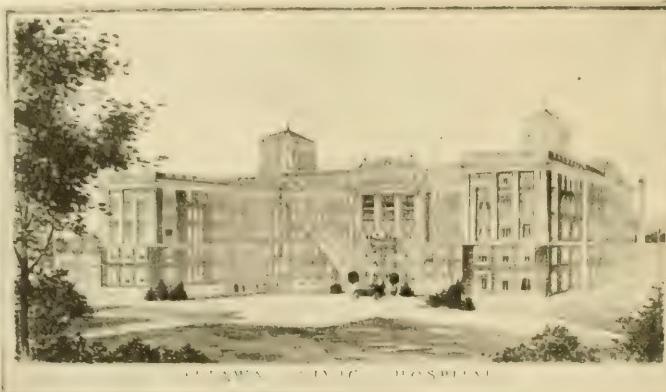
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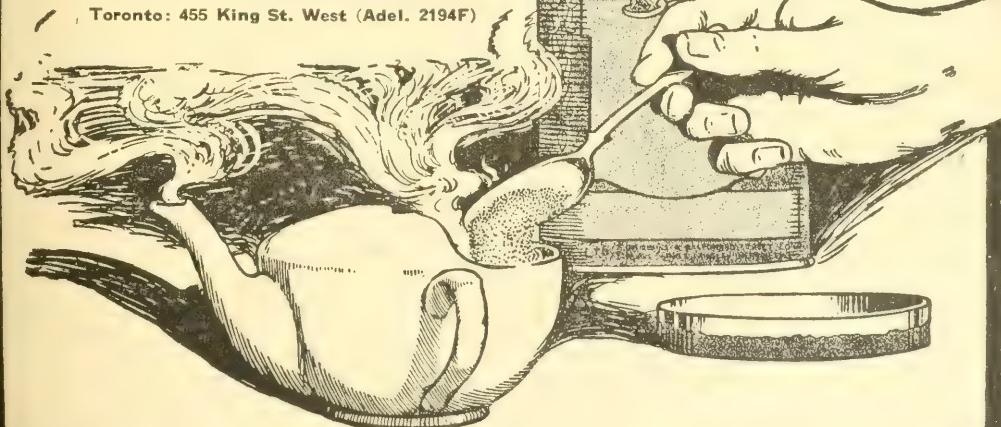
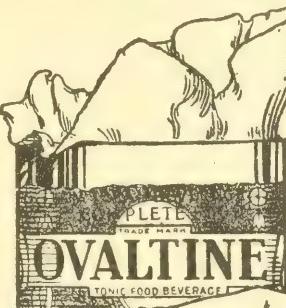
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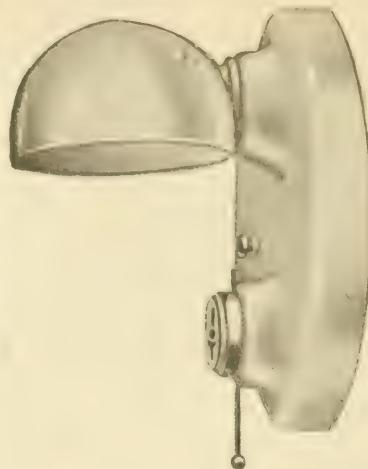
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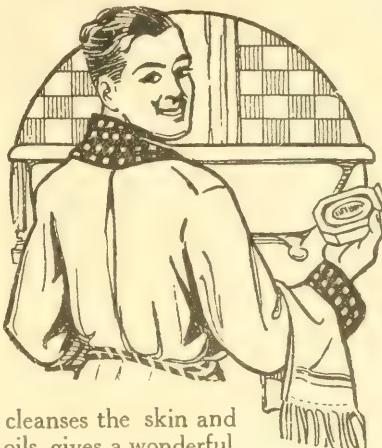
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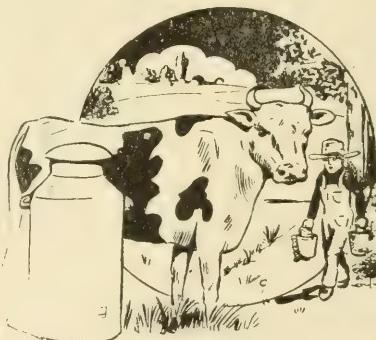
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The Hospital World

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No. 4

Editorial

Nurse and Patient

On a page preceding the printing of an address delivered by Osler to a bevy of Baltimore nurses in 1907, there appears the following appropriate quotations:

I said, I will take heed to my ways, that I sin not with my tongue: I will keep my mouth as with a bridle. . . .—Psalm 39: 1.

If thou hast heard a word, let it die with thee; and be bold, it will not burst thee.—Ecclesiasticus 19: 10.

The author opens by describing the predicament of a sick man. In the hands of the nurse he is as helpless as a lump of clay. “She stops at nothing; and between baths and spongings and feeding and temperature-taking, you are ready to cry with Job, ‘Cease thou, and let me alone.’ ”

Osler describes nurses as “intruders, innovators, and usurpers, dislocating from their tenderest and

most loving duties these mothers, wives and sisters; but they are an added blessing to the household, with certain limitations. At their word one often sees order and quiet replace chaos and confusion, not alone in the sick room and household; having, as Darwin says, 'put all to rights.'

"*Per contra* the nurse, instead of being a messenger of joy and happiness, may become an incarnate tragedy—with a protracted illness, an attractive and weak Mrs. Ebbsmith as nurse, and a weak husband—and all husbands are weak—here are fit elements for a domestic tragedy, which would be far more common were nurses' principles less fixed. On the other hand, the nurse may become a fascination to the sick wife. One poor swain was heard to remark anent the nurse, 'She owns my wife body and soul, and so far as I am concerned, she has become the equivalent of her disease.' "

"Nurses," continued Osler, "are frequently in households the miseries of which cannot be hid; all cupboards are open; they become the involuntary possessors of the most sacred confidences. That part of the Hippocratic oath which enjoins secrecy should be administered to every graduating nurse.

"Taciturnity—a discreet silence—is a virtue little cultivated in these garrulous days, when the chatter of the bander-log is everywhere about us; when, as some one has remarked, speech has taken the place of thought.

"To talk of diseases is a sort of Arabian Nights' entertainment, to which no discreet nurse will lend her talents. . . . The habit of openly discussing

ailments is an abominable practice. This open talk about personal maladies is an atrocious breach of good manners.

"Nurses should resist the fascination of a desire to know more, much more, of the deeper depths of the things they see and hear. This ignorance is very tantalizing, but it is more wholesome than an assurance which rests on a thin veneer of knowledge."

Osler turned once to a fine example of the learned nurse, and asked in a humble tone what the surgeon (whom he had failed to meet) had thought of the case? She replied promptly, "he thought there were features suggestive of an intra-canalicular myxoma;" and when Osler looked anxious, and asked, "Did you happen to hear if he thought it had an epiblastic or mesoblastic origin?" this daughter of Eve replied without flinching, "Mesoblastic, I believe!"

Little Details

The department of the hospital dietitian is today acknowledged as one of the important factors in hospital therapeutics. Drugs have yielded largely to diet lists. A ration, rightly proportioned in food value, of proper quality, and quantity, is recognized as an important element in treatment in every first-class institution.

But, unfortunately, much is still to be desired in the cooking and serving of food in a large number of our hospitals. The carefully selected and well-

appointed tray for the high-priced, private ward may be above criticism, except, perhaps, in its too frequent waste of imported luxuries. But the bulk of the trays in the semi-private and public wards are too often neither attractive nor appetizing. In quantity, quality, or temperature—sometimes all three—the food lacks that appeal to the palate that predicates a good digestion. As a consequence there is both food waste and unsatisfied appetite.

Most patients are peculiarly susceptible in the matter of their food. Its savoriness and appearance mean enjoyment in the partaking. There is so slight a difference at times between the tray that appeals, and the tray from which the patient turns away.

To make the standard of difference in serving food too markedly one of wards, private and public, rather than between the patients themselves, is an error.

The instruction of nurses in dietetics has perhaps been confined too entirely to the chemical aspect. The serving of a simple meal is as important as the cooking of the same. And further, the personality of the patient should enter somewhat into consideration, since there are psychological food values as well as chemical ones.

An intelligent nurse should quickly recognize the varying food idiosyncrasies of each patient, and as far as possible, adapt her tray service to meet each need.

The Spice of Danger

"To have a good time, one must do something injurious to the body," so jokes a clever little take-off. "Nourishing food is always nasty," supplements a hospital patient. Other crisp utterances may be picked up anywhere by an attentive ear to indicate how generally the sentiment still prevails that right and wholesome living is largely a matter of negation—food without salt, life without "punch."

It would be interesting reading if our Health Departments were to issue a bulletin giving directions how to have "a good time" in the common acceptance of the term, sanely, hygienically, entirely wholesome, and yet with the "punch" in it that appears so desirable to all but the very young or very old.

The conception of "a good time" is that of something just a little beyond the ordinary—something outside the humdrum of daily living in food, dress, work and social relationships. It is really adventure that we seek outside the pale of colorless routine of "don't's and do's." When adventure ceases to be adventure it no longer attracts.

A gateway bore the placard, "Keep out—Danger." The boy went in on a tour of inspection.

"I wanted to see what the danger was," he explained later, adding gleefully, as he nursed his splintered arm, "and I found it."

Precisely! He found it, and had the satisfaction accruing therefrom.

Among the many excellent medical health pamphlets let us have one on how to have a good time with "punch"—and safety.

The Hospital World

(Incorporating The Journal of Preventive Medicine and Sociology)

Toronto, Canada

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Editors:

ALEXANDER MacKAY, M.D., Inspector of Hospitals, Province of Ontario.

JOHN N. E. BROWN, M.B., (Tor.), Ex-Sec'y American and Canadian Hospital Associations, Former Supt. Toronto General and Detroit General Hospitals.

M. T. MacEACHERN, M.D., Director-General, Victorian Order of Nurses, Ottawa.
W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont., Consultant, Toronto Hospital for Incurables.
MAUDE A. PERRY, B.S., Supervising Dietitian, Montreal General Hospital

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THE IDEAL HOSPITAL*

MR. A. H. LEANEY, HOUSE GOVERNOR, GENERAL
HOSPITAL, BIRMINGHAM.

My first duty to-night is to offer what defence I can for consenting to read to you a paper on the Ideal Hospital. On the face of it, you might very well object to one who has had comparatively little experience in hospital administration and who has not yet arrived at the age of wisdom daring to lay down what he considers to be the ideal hospital.

But I wish at the outset to make it quite clear that I am not going to attempt to sketch for you *the* ideal hospital but simply my own present idea of what that hospital should be, hoping that by expressing my own views, I may draw out observations and criticisms which may be of use to my audience and to myself.

We constantly hear of the greatness of the work we are called upon to do and we believe it right to style it a vocation rather than a profession or occupation. If that *is* right—and who can deny it?—surely it is worth while for us occasionally to think about it and see how we can best fit ourselves for so high a calling.

I would add just one more personal note. Those responsible for my giving you this paper to-night were influenced, I am told, by a paper, with a similar title, which I gave to our Midlands Branch a year or so ago. Now that paper was really the outcome of friendly chaff. Having earned the reputation of being an idealist, I had often been asked by way of a joke—and my friend the president of the Midlands Branch was the chief sinner—to read a paper on the Ideal Hospital. One evening, much to the surprise of my tormentors and myself, I consented.

However, to-night I do not want you to consider with me the ideal hospital as a joke nor even something worthy of occupying an hour of our time but rather as something it is our duty to consider.

Now what is an ideal, and of what use are ideals? An ideal is something that exists in fancy or imagi-

*Read at a meeting of the Incorporated Association of Hospital Officers, held at 28 Bedford Square, London, Eng., April 27, 1923.

ation only and is incapable of being attained. As one of my best friends would say: "Then why bother about it?"

Nothing of any value has yet been done in this world excepting by those who have followed an ideal. If the human mind is to develop its powers to the utmost, it must concentrate its energies upon something outside itself and also upon unattainable perfection. It is only by so doing that our powers are harmonized and fully developed. If our aim be inwards—on self, in other words—our powers become distorted, stunted and incompletely developed; they may even become divided against each other with disastrous results.

If time and your interest permitted, I would be willing to develop that statement, but it would lead us into a vast subject. If there are any present who would dispute it, a little reflection will soon dispel their doubts.

But the actual attainment of perfection is fortunately not essential to our development; it is the striving towards it that is all important.

I will leave this part of what I have to say by just laying down as an axiom that a striving towards an ideal is essential to the development and progress of the human mind. It applies to everything—not only to hospital work.

I do not intend to spend the time at my disposal by theorizing, and I want, if I can, to deal with practical life and offer some practical suggestions as to how we can stimulate our interest in our duties and increase our efficiency for the benefit of both our hospitals and ourselves. I will try to suggest some ways in which we may get near to the ideal.

So much then for the ideal. May I next endeavour to define a hospital? Of what does a hospital consist? Apart from bricks and mortar and furniture and equipment (things altogether too material to be worthy of consideration to-night) it consists of:

1. The patients.
2. The controlling authority—the governors, the board, or whatever we may term it.
3. The medical staff.
4. The nursing staff.
5. The industrial staff.
6. The domestic staff.
7. The administrative staff.

Let us try to picture the ideal from the standpoint of each of these sections, taking the "average" individual in each case.

What is the patient's ideal hospital? It is an institution where the best medical and surgical treatment can be given and where that treatment is meted out with sympathy and kindness. Where there is no waiting to come in, no irritating delays, no begging for tickets, no red tape, and no unnecessary intrusion of finance while lying ill in bed. From talks with many patients I gather that to be a fair representation of their ideal.

And then the governor's or the board's ideal. The average member of the board as I know him wants to come down to the hospital as often as his presence is really necessary and no more. He is a busy man and can scarcely afford the hour or so a week during which his presence is required. He wants everything needing decision placed before him with brevity and clearness, the point at issue emphasized, and above all, he wants a definite suggestion made to him—he wants a lead. Apart from this, he just wants the hospital to do well, to be economically and properly managed, to be free from complaints from patients and their friends, from adverse criticism in the Press and he wants the hospital to be free at any rate from too embarrassing a debt.

And what does the medical staff look for? First of all of course interesting clinical material, the best equipment, good nursing, the minimum of rules and regulations, cleanliness, smartness, good tone and, above all, a hospital to be proud of.

The nurse looks for very much the same conditions as the medical man in the hospital itself; but she also wants the nurses' home to be equipped on the lines of a college where there will be a pleasant and educative social life. She would also like reasonable remuneration and provision for old age.

The industrial staff is to my mind, a very important section. The hospital engineer, plumber, carpenter, attendant, porter, is usually a most interesting and often a lovable type of man. His devotion to the institution is often

not only very pleasing but very encouraging and inspiring. Apart from his actual work, which brings him considerable happiness, I think he yearns most for consideration on the part of those for whom he works (the ward sister for example) and for a little appreciation of the work when it is done.

The domestic staff is an important section and, while some of its senior members may shew that devotion to the institution and its officers which is one of the glories of hospital work, I fear the ideal for the majority of them would be as little work and as much pay as possible.

And last, but by no means least in importance, comes the administration. Taking the administration collectively, I think they like to feel above all that they are attached to an institution of importance. They like the medical staff to be composed of men of great ability and distinction, the nursing staff to be capable but human. They like to be treated as if they were an integral part of the institution. They want to take a definite part in its work, to do it well and under convenient conditions. They wish their chief to be one capable of holding a definite position in the hospital world, and they look to him to train them as efficient and worthy secretaries of the future. Leaving on one side a natural desire for reasonable remuneration and emoluments, I take it that is a fair description of the ideal as it presents itself to a member of the office staff.

If all these demands are to be met we see how much depends upon the administrator, and in my opinion we cannot over-state how much depends upon him. I feel certain in my own mind that not only does the efficiency of each individual hospital depend mainly upon its head officer but the efficiency and the continued existence of the voluntary hospitals depends ultimately upon the head officers. That is the point I wish to emphasize to-night. That, to my mind, is at once the key and the problem of the future of our hospitals. I believe that the present chaotic condition of the voluntary hospital system and its insolvency is due to the failure of the hospital officer, and its solution can be found only by hospital officers. The urgent question is: can we wake up to that fact in time to save the voluntary system

or shall we be content to expend our energies in demanding with a loud voice that the system must be maintained at all costs and yet do nothing to maintain it?

I do not know whether the president feels tempted to rule me out of order and chide me for leaving my subject; but I suggest that the ideal hospital depends so much upon an ideal head and if he does not appreciate his responsibilities in the direction I have indicated, he falls sadly short of the ideal as I see it.

I should like next to develop the statement that each section of the hospital depends largely upon the chief officer. Let us first take the *board*. What are the main duties of a board? They are responsible to the subscribers and governors for the conduct of the hospital and their duties may be divided into:

1. The getting of income.
2. The spending of it.

Now the getting of income is an extremely important matter and the board ought to have a definite policy with regard to it. They should not allow money to drift in by way of legacies and subscriptions and from the results of spasmodic and sensational appeals. If the work of a hospital were spasmodic it would be another matter, but it is not. The demands are constant, and the whole resources of the hospital are required every hour of the day and night on every day of the year. The income should therefore be constant.

And here we come to a great problem which awaits solution at the present time. With regard to the raising of funds there seems to me to be much chaos, much hysteria and very little clear thinking. The methods or lack of method of many hospitals shew signs of panic. They have beaten the big drums and played on the feelings of the "public" to such an extent that they themselves are played out. They have covered their buildings with devices and mottoes of every kind but still the funds decline to come in. Many have put self respect and all thought of the dignity of their work on one side and given way to the prevailing craze for excitement and something for nothing. I refer, of course, to the

lotteries and ballots which are to my mind a blot on the voluntary hospitals.

There are then two ways of raising money; the spasmodic and sensational appeal and the steady pressure of a well-considered organization suited to the special needs of the district.

The fundamental fallacy underlying the spasmodic, hysterical method is that we can still conduct hospitals as we did a generation ago when they were run for the free treatment of the poor from the superfluous wealth of the rich. Because they were run on funds given voluntarily and because treatment was free, they were called charitable institutions.

I do not deny that much good was intended and done under that system, but I do say that the whole thing was immoral and therefore not in the best interests of the nation. I think it is far more moral that the poor should receive better wages and be in a position to pay for their treatment—I mean indirect payment through their organizations. It was sometimes elevating to the rich to give, but it was very degrading to the others to have to receive. Whether you accept that or not, conditions *have* altered greatly. The surplus wealth is very much in other hands to-day—hands not so ready to give, and the working man does not want charity; he wants to claim his treatment as a right.

We ought to face reality. We are organizations offering the best medical and surgical treatment at the lowest cost which efficient management can give.

That is not necessarily the end of charity. After all, the other was mainly vicarious charity and good deeds lose much of their value when performed by proxy. There is still plenty of scope for charity—and a charity of the highest kind—in the way the treatment is given.

I believe the ideal principle is that each hospital should obtain its own income in its own district by its own methods—each extraneous organization which is set up to try to do for hospitals collectively what each should do for itself only dissipates energy and is detrimental to the hospital in the long run.

Every hospital should have a definite policy as to the raising of funds and that policy should in the case of the larger

hospitals be carried out by a specially trained staff responsible to the administrator.

Where does the hospital officer come in here? you may ask. Well, if a policy is to be successful it must be known to and accepted by everyone working in and for the hospital; it must be the creation of one mind or compiled by one mind. It must not be a patchwork of ideas—some antagonistic to others—contributed by several members of the committee.

The administrator must see that it is understood and accepted by his colleagues, and he, with his intimate knowledge of the hospital itself, the district it serves and the people it serves, is the best fitted to formulate a policy.

Just as the Allies muddled along in the War with a patch-work policy and ultimately found salvation under unity of command, so will a hospital find salvation by unity of policy.

An undoubtedly important help to the raising of funds is a definite and bold policy on the part of the board as regards the facilities offered by the hospital. They should be ready to provide the very best equipment and keep abreast of medical and surgical knowledge. They should also be ready to do their share in research. If extensions are needed they should be taken in hand with confidence. More courage is needed in this direction and hospitals which have adopted this course have shewn it to be the right one.

There is another point which I know will not command general acceptance. I do not believe that a hospital with an overdraft attracts more support than one free from debt. I look upon that as merely another instance of failure to face changed conditions. There is nothing to be gained by juggling with accounts or making transfers to reserve funds, etc. It is far better to tell the whole truth and offer to our supporters a clear statement of the exact financial position.

Another important help is to make the work and the needs of the hospital familiar to its potential users by conducting parties over the hospital. In many institutions this is now a part of the regular routine with excellent results.

In some hospitals the experiment has been tried of asking members of the medical staff to give a simple demonstrations and lectures to meetings of workpeople interested in the hospital. This is an excellent way of familiarizing these

people with the work of the hospital and it shews them how their money is being spent.

If the methods I have indicated are adopted we shall then have travelled a good way towards the ideal, namely, that no patient or member of his family is asked for contributions during the time he is under treatment. If a patient is able and willing to give, let him give by all means, but it is better for him to give during health through his Works Benevolent Fund.

Time will not permit of my saying more on the subject of income although it is of great interest to me. We must consider the board's policy as to the spending of money and the part played by the chief officer in this direction. The old method has often been to go on spending and meeting the demands of the staff after a reasonably protracted opposition and to add up expenditure each quarter. The chairman then makes the usual pessimistic speech which most of us know by heart like a nursery rhyme, and the older members of the board look into the future with horror and say something must really be done while the younger ones are duly optimistic and are quite certain the public will never allow the good work of the institution to suffer for want of funds. Then a special committee is appointed and a lot of money is spent in the getting out of returns, and a lot of time and energy sadly needed in the administration of the hospital is consumed all to no purpose.

The same principle of letting people understand where income is required should be applied to the spending of it. And first of all the board itself should see light.

At the beginning of each year a budget should be prepared shewing the anticipated income, and that income should be allotted under the several heads of expenditure. Month by month the actual expenditure should be compared with the budget, and special requisitions considered in the light of the financial position.

The policy of enlightenment should be carried to the medical and nursing staff and all other sections. Each physician ought to be given in a sample form the cost of his wards and laboratories, and the surgeon the cost of his wards and theatres. And above all the matron and the ward sisters

should know month by month what each individual ward and department is costing. The statement should be as complete as possible, but it must be simple. This method is known as the costing system, and, provided it is not taken to extremes, I believe it to be capable of important results. Not only will it make for saving and general economy, but it will help in the raising of income by giving confidence to the business world.

And for costing to be a success it must be employed judiciously by the administrator; he ought to know exactly what every department is consuming and costing.

It would be extremely useful if each section of the staff were addressed by the head of the hospital each year after the annual report and accounts are published. Not only would such enlightenment arouse interest in the work of the hospital as a whole but it would make for the utmost economy.

Another important duty of the board is to accept responsibility for the welfare of the staff employed by them. It is not sufficient to engage and pay a staff for the several purposes of the institution. It is a duty to look after the physical and moral well-being of the employees. The average works or large office is far ahead of the hospitals in this direction—although some of us are beginning to see our responsibilities.

It has often occurred to me—and I am sure to many of you—what great opportunities are presented for advancement in knowledge and for encouragement of the social virtues by the large number and variety in type of people who live together in our institutions. Not only would the staffs themselves benefit by an organized social life, but the hospitals and the world outside.

It is not only medicine and surgery that have made such great advance in recent years. Equal advances have been made in other sciences, such as education and sociology, and the truths they have discovered for us should be made use of and applied to the benefit of our fellow-workers. Hospitals must not be content to be isolated units; they need in every way to be far more a part of the world outside.

Before leaving the question of the governing body I would like to express my views as to the ideal relationship between

its members and the chief officer. The statement that the latter is appointed to carry out the wishes of his board is only half the truth. He should be capable of forming those wishes. He should lay down policy both internal and external. I do not say that he should openly dominate his committees, but I believe they look to their managing director to lead providing he is not too aggressive. He must administer his ideal as to policy by homeopathic doses—he must master the art of suggestion.

My knowledge of the classics is not a wide one, but there is one passage in Cicero's "de Senectute" which so aptly describes my ideal administrator that I ask your permission to give you a translation of it. He is likening an old man to the navigator of a ship, and says:

"While some climb the masts, some run up and down
the gangways and others are pumping out the bilge-
water, the navigator sits quietly in the stern holding the
tiller."

That would make an excellent subject for a paper on the ideal administrator. It seems to me to set out so well the idea of display of physical energy on the part of others—all necessary and quite proper, of course—and the contrast of self-control and restraint and hidden mental energy of the one who directs the more obvious energies of his colleagues.

With regard to the medical staff, the administrator should try to understand clearly their aims and their policy; he ought to understand in general outline new advances in medical science as they are made. He gradually attains a very fair amount of medical knowledge and is therefore in a position to instruct the lay members of the board in a way they can easily understand. As a quasi medical man and as a layman he makes an excellent liaison between the professional staffs and the lay board at all times. Professional men are notoriously unbusinesslike and unmethedical (although there are, of course, exceptions) and the layman can do much to help by introducing method into their business meetings.

There are many problems affecting the nursing staff, particularly at the present time, and it is essential that we should be thoroughly conversant with them. As so much depends

upon a proper solution a right judgment is important, and the board must see the problems in all their aspects.

The timid policy, or lack of policy, in many hospitals, is doing much to undermine the nursing profession. It is another instance of failure to realize altered conditions. Although nursing has changed from voluntary work on the part of ladies of means to a profession, the conditions of service have scarcely changed. We need well-educated, intelligent women as sisters and nurses, but we decline to offer salaries and conditions which will attract the right type. There is no need for me to dwell on this subject, because it has been so much before us during the past few years; but I would like to add that I personally would offer an attractive salary and pension and really comfortable accommodation to ward sisters in particular, because an efficient staff of ward sisters is the backbone of a well-run hospital.

I have already touched upon the domestic and industrial staff and expressed my view that we need to give far more consideration to their welfare.

In emphasizing the importance of the superintendent, the house governor or the secretary, whatever he may styled, I do not wish to suggest that he is the only person of importance or that he is capable of running a hospital by himself. Far from it. His ability to do good work depends to a very large extent upon those who work under him. His function is to clear the path for the others and see that there is a minimum of hindrance to their being able to develop their powers for the common good. His own experience and his own power will greatly depend upon how much he gets from his colleagues and subordinates. He is the clearing house of information. He must consider, reject and accept as his judgment dictates and, having digested the information placed at his disposal, he hands on the finished product to his board.

No institution can run well unless all, and particularly the heads of departments, can work together. Regular meetings of the heads of departments at which the affairs of the institution are freely discussed are a great help towards smooth and combined effort.

But it requires high qualifications in a man to be able to stimulate many people of different type and temperament to

give their best. It needs high qualifications to assimilate and form correct judgment upon the information and help to be derived from those people. And then again it needs uncommon powers to present a policy to a board in the best way and to stick to it against inevitable opposition and to be undismayed by delays, prejudice and ignorance. All this needs special knowledge of human nature and that can be obtained only if we really understand ourselves.

Think of an average day in the life of a superintendent. Added to all the matters I have enumerated, are interviews with members of every kind of profession and trade. There is every imaginable kind of difficulty to be solved and the way one has to switch suddenly from one point of the compass to its opposite is often quite amusing although that in itself is a tax upon our energies.

What hope is there then that any man could fill so difficult a task with satisfaction? And the answer is: there is no hope. The demands are so great that no one man could entirely fulfil them. The ideal is unattainable. But, given certain conditions, he may gradually get fairly near it.

If one tours the hospitals of this country one is struck most, I think, by the fact that each has its peculiar excellence and that they all differ quite markedly from each other. That, on the face of it, is all to the good; we welcome it as a sign of individuality and therefore of strength. It may, however, also be a sign of insularity and that does not make for strength. If every problem¹ of ours were being faced by those hospitals (each in a different way) it would be pleasing to see so marked a difference, but what we actually find is that individual hospitals are tackling a few of the problems only.

Every suggestion I have made to you to-night as being part of an ideal administration is being carried out with success somewhere. What we must endeavor to do is to unite these successes and, as far as is humanly possible, see that each institution shares them.

Now what are the conditions under which the individual officer may hope to get nearer to the ideal, and under which hospitals generally may share in the sum of individual excellencies? What machinery can be set up to help us?

The machinery already exists in this association of ours. It only remains to use that machinery. It cannot be used to advantage unless the majority are willing to join in making it efficient.

If such an association is to be a success every member must have one aim in view—to give all he possesses freely for the benefit of his fellow members. He should take stock of his opinions on all matters of moment and be prepared to express them at such meetings as this. Very few people enjoy preparing or reading a paper. Apart from the difficulty of persuading oneself that one has anything worth saying, there is always the natural objection to risking making oneself look foolish through failure. But we ought to remember two things. Firstly, if we are right in holding our positions, we must have some experience to recount for the benefit of others, and he is a poor man who cannot express at least one thought, which, if it does not help immediately, will at least stimulate thought and so help indirectly.

To those who have not yet gone through the ordeal of preparing and reading a paper, may I add one word of comfort, and it is this. Even if you make no impression upon your audience and do them no special service you will at least have compelled yourself to face your own views squarely and to form definite opinions on the subject you are dealing with. Not only will that make for peace of mind, but you will often find it of great practical value to yourself and your committee to possess definite views on matters connected with your work.

I should like to say, with all respect, how much I regret the absence from our meetings of men holding the highest posts in our profession. I feel certain from what I know of them that they do not realize how much they could help us and our hospitals by their presence and criticism. If they realized their potential value they would be the last to withhold it.

And we know there are some who do not join us because they object to something or other in our constitution or proceedings. That always seems to me so poor an excuse. Surely the right course for such people is to try to amend those deficiencies and, for the sake of others as well as for their own, to make the association worthy of their support.

An association such as this could play a large part in the ideal hospital; indeed, to my mind the ideal hospital is impossible without it. I know I am at issue with some of our most respected members, but I still believe it a mistake to say this association has no right to consider policy. It has no right to dictate it, but it has a right and a duty to consider it. Without a definite policy—a definite aim—we can never get very far. By giving our attention to questions affecting our own welfare we are dealing with symptoms and not with the disease itself. Let us treat the disease and the symptoms will disappear.

We ought to look at our great work in its relation to the world outside. Europe, and therefore our country, is in the melting pot. Its future cannot be left in the hands of the so-called leaders who are merely men who voice the feelings of the unthinking majority.

Our hospital system is so closely interwoven with the social machinery of the nation that it can play a great part in moulding the future.

The voluntary system stands for unselfishness and sympathy in a selfish, materialistic and thoughtless age. It is worth preserving for itself and for the general benefit of the nation, but without the co-operation for which I plead I can see no hope of the voluntary system being maintained.

And in conclusion I only want once more to emphasize the importance to my mind of our own personal efficiency and our own outlook. If our aim is to fill a position as head of a great institution, and if we intend to measure our success by the number of beds under our charge, and the amount of our salary and emoluments, we shall be utter failures. If we are to succeed we must try to forget ourselves and work with one object only—the highest good for our patients, our staffs, and everyone connected with our hospitals. We cannot succeed if we try to stand alone. Each of us needs all the help that our colleagues can give. Let us give it freely. Let us, by the aid of a united and enthusiastic association, take up the urgent call for a definite policy in the hospital world—a definite ideal. If only we could do that—if only twenty or even a dozen of us could do it—we should ourselves be

amazed at our powers and our progress towards what seemed unattainable.

We are highly privileged men and women. On all sides to-day we hear complaints of the monotony and lack of feeling in the daily work which the majority of people are forced to perform. Their work tends to destroy all that is best in human nature. If our work has a fault it lies in its infinite variety; it is intensely human; it calls out of us all that is best in human nature and gives every hour golden opportunities for the development of character and individual personality. We must not think of its many difficulties except to welcome them as means to an end. And that end must be ideal work carried out under ideal conditions by ideal men and women.

B. C. HOSPITAL FIRE ROUTINE

H. C. STEEVES, M.D., MEDICAL SUPERINTENDENT,
PUBLIC HOSPITAL FOR INSANE, NEW WESTMINSTER, B.C.

The mental organization of this province operates in three separate units, one situated at New Westminster, the old original hospital; one at Essondale, six miles from the city, the new hospital site where our new institution is being built and will eventually be the mental hospital of the province. The third unit, for the insane criminal, is situated at Colquitz, Vancouver Island.

At the parent hospital in the City of New Westminster we have a city fire alarm box at the central porter's desk and the man on duty there is instructed to call the city immediately the institution alarm rings. Every ward and every building of the institution is covered with a Gamewell fire alarm box, which is constantly kept under supervision and in order. Each ward and vantage point about the institution is supplied with Canada La France chemical fire extinguishers and each ward has, in addition, a two-and-a-half inch fire main and fifty feet of hose, which is frequently inspected and kept in constant readiness for use. Alarms are frequently run in and all appliance and apparatus inspected at that time as well as the con-

formity to drill which the nurses, attendants and patients carry out.

Attached is a copy of instructions placed in the hands of every employee, who is expected to be familiar with them and is frequently examined regarding the contents.

NEW BUILDING FIREPROOF

At the new hospital at Essondale, the building is of reinforced concrete construction and contains nothing inflammable except hardwood floors. However, here we also have a fire alarm system and fire mains and hose equipment on every ward and every danger point. For the protection of this building and also for the residences and other buildings about the institution we maintain a motor fire truck carrying large chemical fire extinguishers and hose ladders, lanterns, etc., which constitutes the usual equipment of a fire truck.

At the hospital for insane criminals, also a reinforced concrete and tile building, there is practically nothing inflammable whatever, excepting the furniture and bedding. Here, too, however, we maintain a fire alarm system with fire standards hose and hydrants, and hose in readiness to meet any emergency which may arise.

We are fully alive to the serious menace of fire in a mental hospital and constantly keep before our employees the need of great care in this connection. Our patients are not permitted the use of matches and as much care as possible in supervising their smoking is exercised.

The fire instructions for employees follow:

TO RING IN AN ALARM

(1) Open the door of the alarm box by turning the key. (2) Pull down the hook to the bottom and then release it. (3) Close the door.

The number of strokes and time between strokes tells the number of the box run in and locates the nearest point to the fire. Count the strokes and thus know where the fire is by consulting the box directory card. Each alarm will repeat at least three times, some of them four times, giving ample opportunity to correctly locate the number.

WHEN AN ALARM RINGS, EVERY ONE IS ON DUTY

Go immediately to your ward, whether it be day or night. See that every room is emptied of patients and the doors locked so patients cannot return to rooms. Line patients up in orderly line ready to march from the ward when the signal comes to do so. A second alarm will mean to vacate the building. In case of vacating, take patients to airing court. When all is in readiness to leave the ward, two at-

tendants will remain with the patients and all others go to the location of the fire to assist in fighting it.

AT THE SCENE OF THE FIRE

Ring in the alarm no matter how small the fire may appear. Take no chances. One attendant uses the chemical extinguisher; all others attend to the patients until aid arrives.

Bed patients must be removed to the day rooms, using the blankets as a stretcher and be properly wrapped in blankets to be carried out should need arise. This is important.

A FIRE AT THE NURSES' HOME

Break the glass, thus starting the gongs. Go at once to Miss Fillmore's bedroom and ring in the box located there. Use chemical extinguishers located in the corridor on each floor.

MECHANICAL STAFF AND OUTSIDE GANGS

During the day the dining room steward will ring the bell in case an alarm comes in. All gangs will congregate in charge of one attendant on the lawn in front of the plumbing shop. All other attendants go to the scene of fire to assist.

The mechanics will gather at the fire hall and take hose reel to nearest hydrant and connect up ready for use. Bring out the ladder wagon for use if needed.

The hall porter will put in the city alarm at once when local alarm rings in. DON'T WAIT. *We need all the help we can get.*

Lawn house nurse will start gongs in nurses' home.

At night, the engineer on duty must immediately turn on all lights.

The night supervisor will ring in city alarm, then go to the scene of fire, to assist in the getting out of patients. All others get on duty as quickly as possible and get all patients ready as in the day.

Alarms will be rung in at various times, at least once a month, for fire drill purposes. Whenever the alarm rings, carry out every detail; *it may not be a drill.* Stand in readiness to leave the ward until inspected and instructed to disperse.

Study this thoroughly and know it well. You will have to practise it and know how to carry it out. It will be too late to learn after the fire has started.

ALBERTA'S MUNICIPAL HOSPITAL SYSTEM

ARTHUR K. WHISTON, SUPERVISOR OF ORGANIZATION,
DEPARTMENT OF PUBLIC HEALTH, EDMONTON, ALBERTA.

Oliver Cromwell once said, "Trust in God, my boys, but keep your powder dry"; the philosophy of this statement meaning: Providence helps those who help themselves.

Year after year all over this continent, hospital, medical and nursing associations have been grappling with the all-important problem—the better care of the sick and the provision of the

very best facilities to relieve suffering humanity. The better the service, the greater the cost, and generally speaking, the greater is the burden upon the sick or afflicted.

Is there anything more valuable than human life?

Is there an asset to a country greater than the new-born baby?

If sickness visits a home, is the best service too good?

In a province such as Alberta, which has been described as a country of distances and opportunity, can this service be made readily available when required? This question has been answered in the affirmative by the action of the people of the province themselves.

MUNICIPAL HOSPITALS ACT PASSED

Upon the statute books of Alberta is to be found an act entitled, "the municipal hospitals act," which provides ways and means whereby the people may help themselves and bring within reasonable access, the maximum of hospital service at the minimum cost.

In the early development of a new country, pioneers must necessarily endure hardships and inconveniences, but as development proceeds and population increases, the bitter lessons of the past should teach the people to avoid the experiences of those who have broken the trail. It is only a matter of a few years since the first hospital was put in operation in what is now the province of Alberta, but since the province has been formed, development in connection with all health matters has been proceeding rapidly.

In this country of great distances, the cost for medical attention and hospital service is extremely high. In fact it is not extravagant to say that many people are burdened with liabilities incurred through sickness. The rural people of the province a few years ago decided that ways and means should be provided to bring adequate hospital service nearer to them and, in consequence, cheapen the expense incurred through sickness.

ORDINARY HOSPITAL BEYOND MEANS OF PEOPLE

A hospital to be efficient must be successfully financed. Hospitals operate and keep their doors open, deriving their

revenue by a schedule of fees, which, while not extravagant or out of proportion for the service rendered, makes it practically a penalty to be sick if the service is participated in by persons of limited means. In other words, this type of hospital, in order to function, must depend upon revenue derived from so many sick persons at a fixed sum per day, plus the usual extras in accordance with the class of service rendered.

If this type of hospital, even while performing heroic work and giving satisfactory hospital service, was found to be outside the means of the greater majority of the people, then there was only one alternative and that was for the people to assume the burden collectively and by co-operation, and the municipal hospitals act in an exemplification of this endeavor.

What is a municipal hospital in Alberta? A municipal hospital is an up-to-date, modern, fully equipped institution, built, maintained and operated by the people of a hospital district and supported by direct taxation, this revenue supplemented by a schedule of fees; a place offering service to the persons liable for hospital taxes and to those who are not by the payment of a fixed annual sum; a place where a man and the dependent members of his family may obtain hospital service including bed, board, nursing attendance, drugs and dressings, and the use of the X-ray where installed, at the rate of one dollar per hospital day.

The revenue necessary to maintain and operate the institution and to provide funds for the annual repayment of debenture indebtedness is derived by direct taxation or from revenue paid by the people individually, while well, through a hospital tax. The funds so obtained guarantee the continual operation of the hospital and constant service to those needing care and attention.

Briefly, the municipal hospital system exemplifies the great command, "Bear ye one another's burdens." How often is it found that when sickness visits a home finances are at a low ebb! Therefore, how imperative that in time of health, we should prepare for sickness!

A municipal hospital is a splendid example of applied brotherhood and true community spirit, and is a very strong link in the binding together of the people of the district which it

serves, for the institution is the very exemplification of united effort combined for the common good.

The municipal hospital is governed by an elected board. The capital required for the erection of the building and the annual maintenance and operation charges all are provided by the people of the district. The government pays a per diem allowance of fifty cents per hospital day, under the hospitals ordinance, a similar allowance to that paid any other approved hospital.

The first municipal hospital in the province was erected in 1919 in the village of Mannville and was placed in operation in October of that year. On December 31, 1921, there were twelve municipal hospitals, nine operating and three in the course of construction.

Space does not permit a full description of the general details in connection with municipal hospital activities, but, by comparison with the year 1920, of the records covering the operation of the institutions for 1922, the following statistics might prove of interest:

	1922	1921	1920
Number of hospital days	60,807	39,995	29,585
Number of patients admitted	5,003	3,098	2,439
Number of maternity cases	856	645	444
Number of major operations	408	345	156
Number of minor operations.....	1,074	688	424

SYSTEM SOLVES PROBLEM IN NEW COUNTRY.

Does the municipal hospital system offer the solution, or provide the panacea for hospital ills? So far as Western Canada is concerned, it would appear that the answer should be in the affirmative for it must be remembered that in a new country, capital flows in, not out. Consequently, institutions cannot, for some years at least, become endowed, and it is apparent that only two classes of hospitals can function, namely, the institution deriving its revenue from so many sick persons, or the institution of the municipal hospital type which derives its revenue from so many well persons, who when they are sick and desire service, obtain the same at the nominal fee referred to.

HOSPITAL RATES.

DISTRICT	RURAL TAX RATE	RATEPAYERS' HOSPITAL RATE
Mannville .....	.3c and 3 mills	\$1.00
Vermilion .....	.3c and 3 mills	1.00
Drumheller	3½c per acre	1.00
Islay .....	.3c per acre	1.00
Cardston .....	.3c per acre	1.00
Bassano .....	.4c per acre	1.00
Onoway .....	.3c per acre	1.50
Viking .....	.3c per acre	1.00
Hanna .....	.3c per acre	1.00
Provost .....	.3c per acre	1.00
High River .....	.3c per acre	1.00

The people of this province, more particularly the rural residents, are found to be fully in sympathy and accord with this great movement, and it is not unreasonable to expect that within the next few years, hospital service of the type provided under the municipal hospitals act, will be made available to the great majority of the rural people.

TORONTO'S NEW RECEPTION HOSPITAL

Commencement of building operations on the Reception Hospital, Toronto, to use its official title, brings this city into line with the latest ideas in the way of treatment and diagnosis of mental diseases. Local psychiatrists and specialists in nervous diseases are gratified that the step has at last been taken which enables those who are mentally sick to submit to proper medical care without the revulsion which usually attends the routine of commitment to an insane asylum, while for those in less fortunate circumstances, languishing in jail while the report of an alienist is awaited, will be a thing of the past.

The building which the city is to erect on Surrey Place, adjoins Queen's Park, will accommodate sixty-five patients and a staff of fifty, and is planned as a sort of clearing house for all mental cases in the district, and at the same time will be in a position to administer treatment where observation indicates that a temporary nervous disorder is responsible,

and that scientific care at the proper time will cure a condition which would otherwise be allowed to run on until a long term case, frequently incurable, is developed.

Co-operation of the province, city of Toronto, and the university, in the construction of the hospital concludes negotiations which have been hanging fire for over ten years. Public sentiment first became aroused in 1912, when it was known that some twenty or thirty insanities were left in Toronto jail. Agitation resulted in the opening of the pavilion, in the old general hospital on Gerrard Street, for the purpose of receiving mental cases and for their early treatment, but on the understanding that adequate accommodation would be provided elsewhere. Use of the Gerrard Street buildings as a barracks in 1914 necessitated the removal of the ward to Trinity Park, however, and the work was carried on under handicap until 1919 when the reception hospital idea had to be temporarily abandoned owing to the dilapidated condition of the building in which it was being carried on.

Discussing the cases handled in this short time, Dr. Harvey Clare, Superintendent of the Ontario Hospital, who directed the work, said: "Of 3,000 cases which came to our attention, 1,900 improved to such an extent under the treatment which we gave that they were able to be returned to their homes. The remainder proved too far advanced, and were transferred to Queen Street."

Discussion of sites and plans continued until 1921, when the University of Toronto, desirous of securing better facilities for the teaching of psychiatry, offered the site on Surrey Place, according to the provisions of an Ontario statute, with the understanding that the city would furnish the building, and that the province would staff, administer and maintain the new organization. An agreement to this effect was drawn up a short time ago under the direction of Sir William Meredith, and permitted the start of the building operations, once signatures were affixed.

Need for a specialized hospital of this kind reflects the latest ideas on the treatment of mental disorders, according to statements of local psychologists. Insane people are of two kinds, it seems—and by "insanity," is meant any condition

which renders a person unfit to look after himself or his affairs—those in which a crisis which will be reached, and with proper attention, safely passed, and those which prove chronic attacks requiring prolonged treatment in the recognized institutions for the purpose.

Commenting on the place which will be filled when the new building is in operation, Dr. Eric K. Clarke, psychiatrist for the department of public health, stated: "The Ontario hospital is equipped primarily for the treatment of well defined cases of mental disorder, and the one who is afflicted with a mild attack, or whose case is in doubt, may be treated in the General Hospital, or he may be kept under observation in the jail. Such patients should not be mixed with ordinary medical or surgical cases, however, as happens in the General, while the jail is not the place to take care of sickness—and mental cases are just as responsive to scientific treatment as are any others. People suffering from a nervous breakdown are one type of patient who will be dealt with at the new hospital. Frequently due to highly strung nerves, 'nervous breakdowns' can be cured after three or four weeks of proper care."

It is for this reason that special provision will be made in the equipment for hydrotherapy, and for electrical treatments. Baths of various kinds have been found to work wonders in the case of persons whose nerves have secured the upper hand.

Patients need have no hesitation in taking treatment at the new hospital. Treatment at such a place is nothing to be kept dark, or to be lived down. Further, it is hoped that should examination indicate that the patient is a chronic sufferer, he and his relatives will look with greater favor on admission to an Ontario hospital, because they will have the satisfaction of knowing that there has been no superficial examination, or careless certification to an asylum.

No stigma attaches to treatment at certain sanitaria in the province, although the cases, and frequently the treatment, are similar.

An out-patient department will be a feature of the Reception Hospital, which will make periodical examinations of those discharged from Queen Street, from Whitby, and from

its own wards. Likewise, social service workers will keep track of certain of the patients, as a percentage, particularly those ordinarily treated at the jail, are known as delinquents. Curable pathological conditions will be eliminated as stumbling blocks in the paths of these unfortunate sufferers, however.

"Insanity in its many forms is attributable largely to three factors," Dr. Clarke explained. "General medical conditions, and to some extent inherited weakness, are responsible, but there are many precipitating factors, such as shock, worry, or overwork. The modern idea of psychiatry is to take hold of your case early, and clear it up, before it becomes a permanent institution case."

The hospital will provide facilities for the teaching of psychiatry to medical students, which have been needed for some time, and it is expected will be opened in approximately one year's time.

NATIONAL HOSPITAL DAY CELEBRATION AT THE ROYAL ALEXANDRA HOSPITAL, EDMONTON, ALBERTA

A programme was prepared several weeks in advance which provided for a celebration extending over a period of four days. On the evening of May 11th the annual nurses' graduating exercises were held, at which prizes, diplomas and pins were presented, and a very inspiring address on nursing was delivered by Dr. Fuller MacPherson, one of the city's most prominent physicians. On the following day, May 12th, at two o'clock in the afternoon, citizens and friends visited the hospital. A large platform having been previously erected on the hospital grounds immediately adjacent to the front entrance, short addresses were delivered by the chairman of the board, Mr. W. T. Henry, His Worship, Mayor Duggan, and the medical superintendent, Dr. H. R. Smith. These were followed by a most inspiring address by the Rev. Comyn-Ching, Rector of Christ Church, on the "Life of Florence Nightingale."

Following this address the Lieutenant-Governor, Dr. Brett, in a very pleasing and able manner, conducted the ceremony of unveiling a beautiful bronze tablet, which was presented to the hospital by the Women's Hospital Aid, inscribed on which were the names of those who had contributed to the furnishings of the hospital. Another very pleasing feature of the afternoon's programme was the planting of a tree by the nurses of the 1923 graduating class. This was presided over by Mr. J. A. McDougall, one of the old-timers of the city, who has been, for many years, greatly interested in the work of the hospital.

The 49th Battalion Brass Band was present. The music rendered by them was excellent, and was greatly appreciated, not only by the visitors but by the patients all through the hospital. It was feared by some that those very ill might be disturbed by the music, but without exception the patients expressed themselves as being grateful for the opportunity of listening to the splendid entertainment.

All mothers who had babies born in the hospital in the last two years had been invited, some six hundred and seventy-five invitations having been sent out. A great many of them responded and brought their children with them. Refreshments were served on the grounds and an opportunity was given the visitors to inspect the hospital. On the following day, Sunday, May 13th, the Salvation Army Band rendered excellent music on the hospital lawn which was thoroughly appreciated and enjoyed by the patients and their friends. On Monday, May 14th, the ratepayers of the city were given an opportunity to express, by ballot, their approval of the hospital by-laws totalling \$115,000. The members of the hospital board, Women's Hospital Aid, and all the friends of the hospital did their utmost to induce the citizens, on this occasion, to vote favorably for these by-laws with the result that they carried by a large majority. This money is to be spent in erecting an addition to the Nurses' Home, a new laundry and an extension to the heating plant. This was the first occasion on which the Royal Alexandra Hospital undertook to celebrate National Hospital Day and it was, undoubtedly, a very great success.

NEW NURSES' HOME OPENED AT WHITBY.

With Mrs. W. J. Hanna to formally officiate and with Hon. Dr. Forbes Godfrey to deliver a brief address, the Conservative administration which did so much to inaugurate enlightened care of the feeble-minded and the one which is now seeking to continue that policy, were linked together at the opening of the two new nurses' homes at the Ontario Hospital, Whitby, on August 15th. It was Hon. W. J. Hanna, whose widow performed the ceremony, who gave special attention to the development of the Whitby institution, and the opening of the nurses' residence added to it a detail of equipment which must inevitably make for its greater efficiency, as well as for the greater comfort of the nurses who make the care of the unfortunate patients their mission.

The buildings themselves are thoroughly modern in equipment and conception. Built somewhat in the bungalow style, they are airy and light to an extent which makes them cheerful. They are furnished in a manner to make them most attractive as well as most comfortable for their inhabitants. They represent a thoroughly progressive idea of construction, and are designed to fit in suitably with the development of the institution to one caring for 2,000 patients, which Hon. Dr. Godfrey forecasted in his address.

Hon. Dr. Godfrey spoke briefly of the manner in which hospitals were a reflection of civilization and suggested also the plans for expansion of the Whitby institution which he entertained. "In 1921," he said, "when the last census was taken, I believe the population of Ontario was 3,000,000. In the different hospitals for the treatment of mental diseases on October 31st, 1921, there were 7,734 patients. This was the actual number who slept in hospitals that night, and does not include those visiting or out on probation. Approximately this is one of every 380 population. In newer provinces the proportion is not so great. For instance, in Massachusetts and New York State, where the organization is more thorough and older, the percentage is considerably larger. Down in the Southern States the percentage is one in 800. In other words, the better you make your hospitals, and the higher the degree

of civilization, the more people will be picked up and placed in hospitals.

"In 1921 the population of the various hospitals for mental diseases in Ontario was increased by 271. In 1922 this population increased by 384. When times are hard more people are forced to place their relatives who are mentally afflicted in hospitals. When people are working and have money they frequently take their patients out and provide for them at home.

"I do not think that insanity is on the increase, but when Ontario has a population of 4,000,000 you will have approximately 2,000 more patients in mental institutions than we have at the present time.

"This institution, The Ontario Hospital for Mental Diseases, beautifully situated on the shore of Lake Ontario, with an area of probably 500 or 600 acres is a new institution begun in 1912, and probably the finest hospital of its kind in the world. A lasting memorial to one of Ontario's greatest men, Hon. W. J. Hanna. It will probably accommodate 1,500 and I think that before many years have passed we can probably reach 2,000, and from an economic standpoint this will reduce the per capital maintenance cost."

Speaking of Dr. J. Forster, superintendent of the Whitby Hospital, Hon. Dr. Godfrey paid a glowing tribute. The speaker referred to him as one of the ablest men in the medical profession in the province, and certainly one of the most suited for the great responsibilities which the position carries with it.

The Government was also represented by Hon. George Henry, Minister of Public Works, and by various officials of the Provincial Secretary's Health and Public Works departments.

SCOTCH SURGEON ARRIVES

Among the cabin passengers to arrive on board the C.P.R. Montrose from Liverpool on August 24th, was Sir Henry M. Gray, M.B., F.R.C.S., eminent Scottish surgeon of Aberdeen, Scotland, who has come to Canada to take over the duties of chief surgeon at the Royal Victoria Hospital in Montreal.

NATIONAL OFFICE, CANADIAN NATIONAL ASSOCIATION OF TRAINED NURSES

The Executive Committee of the Canadian National Association of Trained Nurses wishes to announce that a National Office for the Association has been established at 609 Boyd Bldg., Winnipeg, Man., with Miss Jean S. Wilson, Reg. N., Executive Secretary, in charge.

The nurses of the various associations affiliated in the National Association have long felt the need of a headquarters' office with a full-time secretary, and at the annual meeting held in Edmonton in June 1922, a majority vote of the associations represented decided on the establishment of such an office.

It is the wish of the members of the National Association that this office should become a bureau of information for the various branches of the nursing profession in Canada. Nurses wishing to obtain positions should send a request to the executive secretary for an information form. Hospitals, institutions and organizations employing registered nurses are recommended to refer to the executive secretary when wishing to obtain the names of nurses available for their needs. No fee or commission is charged for any assistance received through the National Office.

The duties of the treasurer and archivist have been delegated to the executive secretary.

MEMORIAL HOSPITAL AT ST. THOMAS

Beneath the fairest of summer skies, the corner-stone of the Memorial Hospital, the \$200,000 institution that is being erected north of the Amasa Wood Hospital in honor of St. Thomas' sons and daughters who served in the late war, was laid with fitting ceremonies by Col. Harry Cockshutt, Lieutenant-Governor of Ontario, on August 29. Hundreds of persons from the city and country witnessed the event, and tendered his Honor a royal welcome. In the evening his Honor and members of his party were guests of the city at a brilliant banquet in the Grand Central Hotel, at which some 150 attended. An automobile drive around the city and a public

reception in the Chamber of Commerce clubrooms preceded the banquet.

An illuminated civic address was presented the Lieutenant-Governor by Mayor Raven at the corner-stone laying, and also a silver trowel from the architects, Messrs. Darrach & Findlay of St. Thomas.

The presentation of the British Admiralty war service medals to seven members of the local St. John's Ambulance Brigade also took place in connection with the hospital ceremonies, the Lieutenant-Governor officiating.

Dr. C. J. Copp of Toronto, Assistant Commissioner of the St. John's Ambulance Corps, introduced the nursing sisters, and spoke briefly on their splendid record in the war.

The completion of the hospital is anticipated early next year. It will provide accommodation for sixty beds, and will be equipped with all the modern facilities. One of the features will be a large memorial hall in which tablets setting forth the deeds of the local soldiers will be erected. The other memorial feature is the extension of free hospital care and treatment to all returned men of the city in need of the same.

DEFICITS IN THE TORONTO HOSPITALS

Four of the Toronto hospitals, Grace, Western, General and St. Michael's show deficit on maintenance for the year of \$2,442, \$18,130, \$29,501 and \$8,035 respectively, and the Hospital Commission has asked the Board of Control for payment of fifty per cent. of the amounts, which was agreed to. The City Auditor reported that he concurred with the auditors of the hospitals' accounts.

GIVE CASTLES FOR HOSPITAL PURPOSES

Lord Londonderry and Lord Boyne have made generous offers to present Seaham Hall and Brancepeth Castle respectively to Durham County for hospital purposes, notes the Durham correspondent of the *London Times*. Both Seaham Hall and Brancepeth Castle are admirably situated and easily adaptable as hospitals or convalescent homes, and were so used

during the war. Brancepeth Castle has been the seat of the Russell family since the eighteenth century. Originally built before the conquest, Brancepeth dates from an earlier period as a castle than any other in the country. Lord Boyne is now living at Burwarton, Bridgnorth, Shropshire. Seaham Hall was closed by Lord Londonderry owing to heavy taxation and the cost of upkeep. It has been in possession of the Londonderry family since 1822.

BIG BLAZE IN HOSPITAL

Damage estimated at \$30,000 was done on July 12th to the General Hospital at St. Catharines, when fire broke out in the old wing of the institution. The nurses acted with great bravery, carrying and assisting patients to places of safety through heavy smoke, which soon filled the building.

Fortunately, the hospital was not crowded, there being only about sixty patients. The fire originated in a maid's room in the third storey, presumably from an electric wire, and the flames spread in all directions, going rapidly through the roof. Firemen were quickly on the scene and had a hard fight to stamp out the blaze, which was not easy to get at.

Book Reviews

Success in Practice, by C. H. Ash—a Brochure, published by the Roycrofters for The Spencer Lens Co., Buffalo, N.Y.

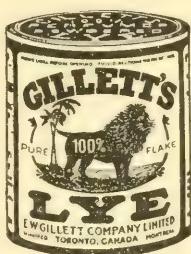
This is a brochure that, from a mechanical standpoint, is a credit to any firm. It is "Roycrofter" all the way through—the paper is most beautiful and the printing a credit to the trade. The brochure is most interesting, giving a great deal of information regarding Pasteur, the father of bacteriology, and one of his successors, C. A. Spencer, (born in Lenox, New York) who devoted his entire life to optical problems, particularly the development of the microscope and the origination of the Spencer Lens Co. of Buffalo, whose microscopes are so well known in Canada. The brochure will be sent free of cost to any physician making request for a copy.

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for disinfecting sinks, closets and drains. It is also ideal for the cleansing of urinals and bed pans—in fact any vessel that requires disinfecting. Gillett's Flake Lye should always be used for scrubbing hospital bath tubs and operating room floors.

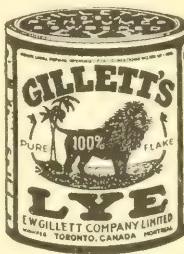


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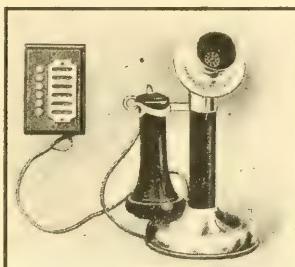
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SOFT WATER IN THE HOSPITAL.

The hard water problem in the hospital, which has been the cause of extensive inconvenience and large expenditures in the past, has been solved. It is now possible to have soft water anywhere. No longer is it necessary to be located where the water supply is soft to be able to reap the immense benefits which can be derived by its use. There are now on the market machines to soften hard water by removing the troublesome salts of lime and magnesia, which cause this hardness. These machines, or softeners, are small, compact, easily operated and inexpensive. They require very little attention and the water is softened instantaneously as it flows through the mineral bed. This mineral is a substance supplied by nature. It is mined in a natural state, and processed for commercial use. The softener consists of a tank or container filled with this mineral, with the necessary valves and piping to control the flow of water through the machine, together with a brine tank to hold the brine used for regenerating the mineral bed.

The advantages of using soft water in a hospital or institution are numerous. In the laundry department the use of soft water saves from thirty to sixty per cent. of the washroom supplies, which in itself is a large saving. In addition to this, there is no soap curd left in the linen after washing. This results in a much cleaner and whiter quality of work, and leaves the linen with a sweet, fresh odor. This curd is formed by a combination of soap and the hardening salts in the water, and cannot be washed from the linen. When hard water is used, large quantities of soda and bleach are used to counteract the hardening salts, which have a detrimental effect upon the linen. This is done away with when using soft water, with a resultant saving in linen replacement. This saving is an important item, and in most cases is higher than the saving in supplies. In the boilers, soft water eliminates the scale already formed, and prevents new scale from forming, thereby reducing the fuel consumption considerably. No boiler compound is used with soft water, and the elimination of this item means additional savings. Soft water is excellent for the bath, for shampooing and general toilet purposes. It is not irritating to the skin and after shampooing, leaves the hair with a brilliant lustre. Many hospitals have already installed water softeners, with the result that their hard water problems have been definitely and efficiently settled. Further information regarding water softening and filtering equipment, for any purpose, may be obtained without obligation, from The Refinite Company of Canada, Limited, 305 Continental Life Bldg., Toronto, Ontario.

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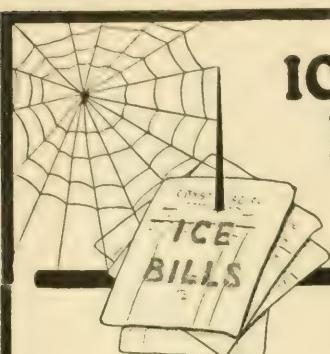


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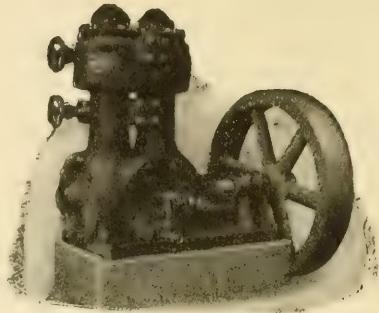
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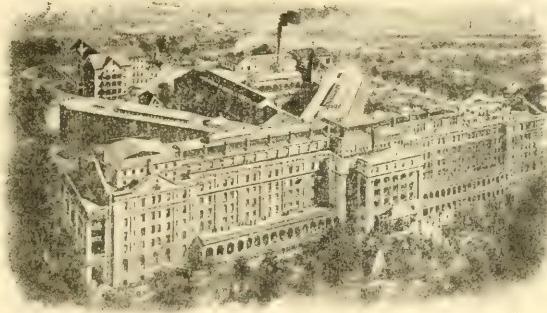
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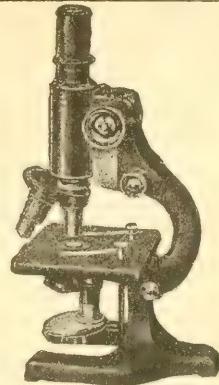
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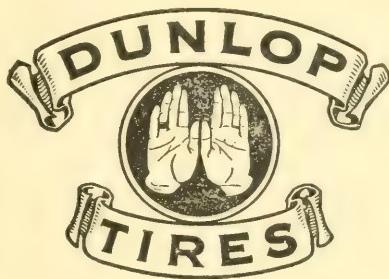
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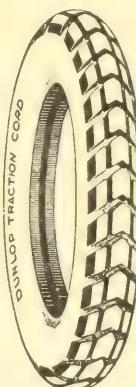
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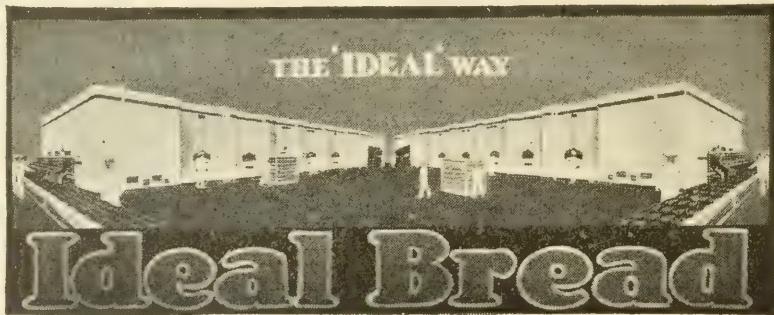
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THE HOSPITAL WORLD

Vol. XXIV

Toronto, November, 1923

No. 5

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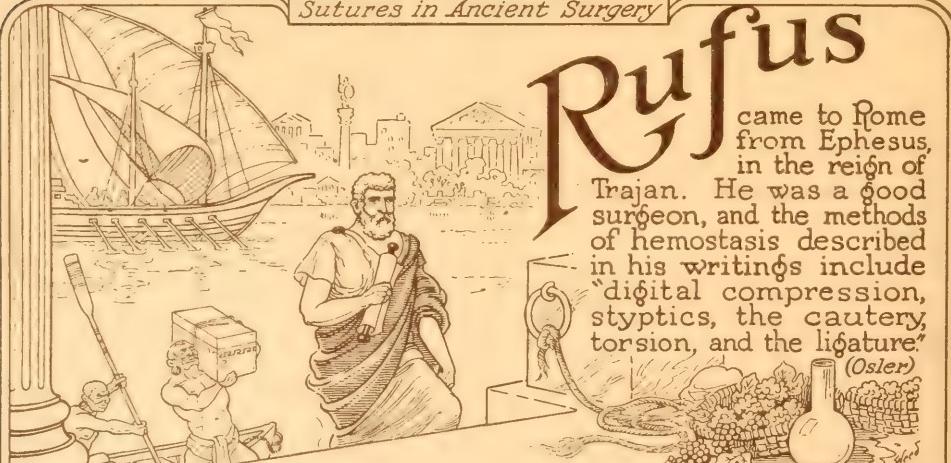
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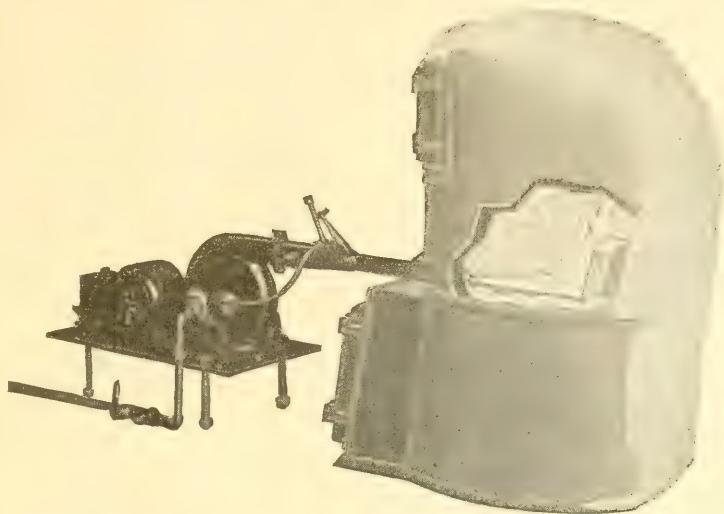
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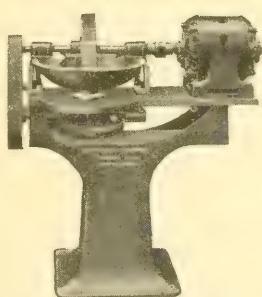
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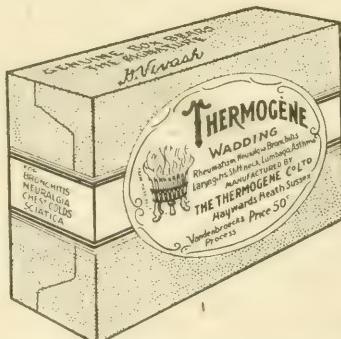
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The Hospital World

TORONTO, CANADA

A Journal published in the interests of Hospitals, Sanatoria, Asylums and Public Charitable Institutions throughout the British Empire.

Vol. XXIV

TORONTO, NOVEMBER, 1923

No. 5

Editorial

British Hospitals

The section of the British Medical Association on Medical Sociology at its recent meeting, discussed the relation of the medical profession to local authorities in respect of rate-provided hospitals and clinics. Sir George Newman, Chief Medical Officer of the Ministry of Health, pointed out that there were some 45,000 beds in the voluntary hospitals, which hospitals are now in some degree state-aided through grants of public money for care of ex-soldiers, or the treatment of venereal disease, tuberculosis and certain maladies of infants and school children. Their Poor Law hospitals and infectious disease hospitals, supported by the rates, supplied 135,000 beds; 18,000 beds were given over to tuberculosis in sanitariums and hospitals, and 128,000 beds were occupied by the lunatic and feeble-minded.

They were now faced with a wholly new issue of a medical service in rate-provided institutions. The type of patient admitted to rate-provided hospitals has been determined by mutual consent on the basis

of the character of his disability. Poor Law hospitals had performed an essential service, the voluntary hospitals had contributed much to the progress and freedom of medicine, and had brought into the enterprise an immense volume of gratuitous and altruistic service, saving the ratepayer heavy taxation. None of these advantages should be sacrificed.

Sir George contended that they should retain and cultivate their historical sense—the sense of proportion. They were now passing through a marked transition in social development; hence they should walk unusually circumspectly. There was (1) a deplorable shortage of hospital accommodation and likewise an equally deplorable absence of differentiation in function of hospitals; (2) the national insurance system affecting 12,000 doctors and 14,000,000 insured persons; (3) the exigencies of war and the ravages of certain diseases had led the state to call for emergency action in regard to maternity and child welfare, tuberculosis and venereal disease; and (4) there had been an immense revolution in the science and art of medicine both in its curative and preventive sides which had profoundly affected men's minds.

Although ideal national arrangements should be the final goal, it was necessary to take one step at a time, conserve what is good and discard the injurious or useless, having regard to the amount of money available and to the relative value of experiment and precedent.

Three questions occurred to Sir George: (1) What does the local authority require? (2) Can the local authority meet its obligations in institutions by a whole-time medical service? and (3) how best can the authority's medical requirements be met?

Answering the first query, Sir George maintains that there should be a proper co-ordination between institutions and public and voluntary medical agencies, that patients should be selected on grounds of urgency of physical need, necessity for skilled treatment, home circumstances and priority of application. Patients should pay in whole or in part for services rendered.

As to a whole time service, Dr. Newman thinks that is not needed. Such a measure sacrifices the goodwill of the local medical practitioners, the co-operation of local voluntary institutions and agencies, and, furthermore, sacrifices a goodly measure of local medical experience and freedom and mobility for the institution, its staff and the local doctors.

Third, the authority's medical requirements are best met by securing the speedy recovery of the patient. To this end, doctors should be associated with the governing board; there should be a medical staff committee for the medical administration; services of local practitioners should be secured; the medical staff should be paid for their work; their tenure of office should be fixed; the part-time staff should recognize the suzerainty of any whole-time

medical officer; and there should be a local medical advisory committee appointed by the medical profession in the district, which should be consulted by the authority on important medical propositions affecting the institution.

Justice Adams thinks that a State medical service will ultimately be evolved, the voluntary hospitals becoming absorbed in the scheme of publicly maintained and controlled institutions. Pending such consummation, the Government should grant aid to hospitals through the principal municipal authorities, who would have representatives on the boards. Judge Adams favored the formation in each local health area of a medical advisory council with power to make recommendations and issue reports for the consideration of the local health authority and the public. One body would administer, the other initiate, new and extended health organization. Combined they would blend both preventive and curative work.

The part-time doctor would be allowed to attend the communal hospital. There would be a ward for private patients attended by their own doctors. In rural areas full-time doctors would not be needed. A whole-time officer would act as administrator.

Music in the Air

Hospitals in many places are installing radio sets—hospitals for children, for the insane, for the aged, for incurable patients, for the tubercular, and

for patients in general hospitals. What a boon for these poor folk!

For ten years or so occupational therapy has been the slogan for convalescent patients, and those well enough to use their hands at basket-making and other sorts of handicraft. But occupational therapy now has a strong rival, the radiophone which amuses, instructs and entertains during the hours, days or even weeks which the sufferers have to put in until their discharge. Concerts, lectures, sermons, reports of games and markets, general news—all to be heard by "listening-in." And the best is broadcasted. The best singers, the best players, the best bands, the best lecturers and the best preachers—and all brought to the patient; no effort necessary, except to listen; borne on the ethereal waves over hundreds of miles, waves which thickest walls of stone or steel cannot exclude.

One writer says, "It is as though the great Architect of the Universe has revealed to us a little of the unknown Beyond where space shrinks before His will."

And how simple and comparatively cheap the equipment! Also simple to build and simple to operate. *The modest sum of \$150 will install a set in one of the smaller hospitals; \$250 will go further. The amount required depends on the site of the building, the size of the outside wire and the number of accessories purchased.

The best plan for a hospital is to have a central control station and a loud speaker which can be

*Full particulars can be obtained from the Gibson Radio Supply, 104 King Street West, Toronto.

transported from room to room. In such a construction leads are brought into the various rooms from the central control station and the loud speaker attached to these leads.

Where hospital buildings are separated or consist of isolated cottages, these separate buildings must be equipped with a telephone service. In the control room the loud speaker is held before the transmitter of the phone. The switchboard operator then opens keys on the lines of those wishing to "listen-in." Near Boston is a tuberculosis hospital of twenty-seven cottages. All may "listen-in" at one time to concerts relayed by the control station.

An unusual application of loud-speaking equipment is reported in *Radio Electricité*, in connection with the operating room of a French hospital. It appears that above the operating room in question there is a glass roof through which the operations being performed by the surgeon may be followed by medical students. The surgeon, while performing the operation, talks into a microphone in the operating room, and the current is amplified through ten vacuum tubes, for delivery to a battery of loud-speakers in the observation room above. In this manner the medical students not only see what is being done in the operating room, but they receive the explanations from the surgeon at the same time.

And now with a thousand and one broadcasting stations on the continent nearly every one of the 7,000 hospitals can, from one or other of them, pick up the music in the air. The day of miracles is not over!

A Sacred Hospital Trust

Canadian men and women of wealth have not yet learned how good a thing it is to dedicate a portion of their means to philanthropies that will serve humanity through long years after their decease.

One of the regrettable points in connection with the large majority of wills that dispose of big estates is the small amount, if any, that is set aside for such a purpose. Million dollar estates, or half, or quarter, are divided among the immediate family of the deceased, with the sop of a few pitiful hundreds bestowed upon one or more charities. Both England and the United States are ahead of us in this respect. Many of their finest hospitals have been established or endowed in this way. As the donors have prospered, so they desire to reach outside their family circle and confer lasting benefit upon the larger circle of their fellow citizens.

But it is not often that years of stern self-denial and economy precede such giving as in the recent case of one aged woman.

Mrs. Emily Jane Smith, of Chicago, aged 84, whose recent death brought her will to probate, has placed an estate of \$800,000 in trust for the establishment of a million dollar hospital and home for the aged, in memory of her father and mother. She was not a wealthy woman, for the terms of the will reveal years of the strictest economy on her part in order that her life-long dream of such a monument to her parents might be realized.

Here is a vision: The daughter growing slowly into advancing years, treading the path of gradual oncoming infirmity and weakness that her parents trod; having memories possibly of what they lacked that she could not give them; realizing in herself the needs and loneliness of age; economizing even in the eighties and passing away knowing that her dream would be fulfilled.

What a monument!

Cheer in the Hospital

In a course for nurses given in connection with the Toronto University extension lectures in August one of the professors related in amusing and graphic way his personal experience during a brief visit to one of the large Toronto Hospitals for a tonsillectomy.

He described the air of jaunty fearlessness with which he entered the hospital portal, under the cheering pre-assurance of his physician; and how his courage slowly evaporated as he was passed through the formalities of admittance, room assignment, and initial nursing routine.

"My first chill came," he said, "when having given my name and address, the business-like young desk official requested the name and address of my nearest relative. 'What for?' I asked. 'In case we need to notify them,' was the cryptic reply."

The professor proceeded to describe the well-known routine of entrance and preliminary service: how nurse one and nurse two and interne took successive possession of him—each by their sober mien

and crisp official comments further reducing his courage.

"Look here," I said, when clad in pyjamas and in bed a clinical thermometer was thrust in my mouth. "I'm well. There's nothing the matter with me; I've only come to have my tonsils . . . 'Keep your lips closed, please,' said the stiffly starched young woman with her eyes on the instrument and her fingers on my wrist."

The professor slept soundly through the night, had his tonsils out in the morning, and returned to his home two days later. But his amusingly told experience formed the text of a strong appeal to the class of nurses before him, that they would endeavor to give a cheery personal touch to their services, especially to incoming hospital patients. The stiffly starched atmosphere of a hospital should be kept as much in abeyance as possible.

"Serious looking physicians and surgeons must become human in the minds of the masses," says Mr. R. W. Keeler. "Nurses must come to mean more to patients than mere stiffly-dressed young women who report to the doctor and take his directions."

Certain routine forms and procedures are essential in connection with hospital service; but every person who enters the institution for the first time as a patient is in a mental and physical condition that makes him keenly sensitive to impressions. Therefore, as the lecturer entreated in his closing words, "Nurses, smile; do smile!"

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Editors:

ALEXANDER MacKAY, M.D., Inspector of Hospitals, Province of Ontario.

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M. T. MacEACHERN, M.D., Director-General, Victorian Order of Nurses, Ottawa.
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Original Contribution

REMARKS ON THE FOOD FACTOR IN CARDIO- RENAL DISEASE

SOLomon STROUSE, M.D., CHICAGO, ILLINOIS.

These somewhat rambling remarks are intended as an attempt to evaluate the food factor in the treatment of those clinical syndromes associated with diseases of the heart, kidney and blood vessels. It is almost necessary to group these three systems together as one big system for therapeutic purposes, for it is indeed rare to see a disease affecting the heart without also disturbing the kidney function, or to find arterial disease not complicated by disturbances of the heart or kidney. Although one must group these systems together, in the individual patient who comes for treatment, success in therapy depends upon our ability to differentiate which organ is bearing the brunt of the trouble at that particular time. For instance, an anuria due to a weakened heart muscle certainly calls for different treatment from an anuria due to an acute inflammatory process in the kidney proper. High blood pressure without disturbance of renal function and without the retention of nitrogenous end-products offers a therapeutic problem differing in every detail from the same degree of hypertension in a patient with advanced renal, arterial and myocardial changes. Often the effort to determine the organ vitally affected meets with success only after most careful history-taking, physical examination and painstaking laboratory work.

If this introductory premise is accepted, it becomes apparent that generalization regarding dietetic indications in any of the diseases under discussion becomes impossible. Unfortunately much of our present-day knowledge of food is not knowledge at all; it is the result of traditional adherence

to empirical formulae. To doubt the danger of protein food in high blood pressure is almost heresy, while the scientific basis for this belief is very slight. If we wish to start the discussion with a consideration of hypertension—a common characteristic of the cardio-renal diseases—we must at first realize that hypertension represents merely a symptom. I have recently pointed out¹ that in frank renal disease with advanced arterial and eye changes the protein intake could be varied sufficiently to change the non-protein nitrogen and urea nitrogen of the blood without in any way affecting the blood pressure of such cases. On the other hand, in cases of so-called essential hypertension, the blood pressure could be made to drop by mere physical quiet, and relief from worry, regardless of the amount of protein ingested. It would be obvious folly to attempt to treat a patient with hypertension actually due to improper living, excessive worry, or syphilis simply by restriction of the protein or salt intake without paying due attention to the actual causative agent in the particular case. Furthermore, attention should be called to a very evident danger arising from the poorly balanced diet in which protein is replaced by excessive carbohydrates. Mosenthal² has again called attention to the fact that overweight resulting from excessive carbohydrate intake has a potential value for harm in hypertension considerably greater than a little extra protein.

At all events, the importance of food or of one particular article of food should not be over-emphasized to the exclusion of other features. In each individual patient, it is necessary to evaluate not only the diet factor, but also the questions of general hygiene, exercise, worry, work, smoking, alcohol, domestic life and numerous other psychological elements which influence or might influence the sick man. This is necessary from the therapeutic as well as the etiologic point of view.

There is no need to discuss the treatment of the frank acute nephritis cases, nor is there any great need of going into details concerning the second stage of acute nephritis, the long period during which the patient becomes pale, weak, and more or less of a chronic invalid with the renal function still markedly impaired and the outcome always in doubt. There

is, however, one point in connection with this stage of nephritis which seems to be of importance, that is, the use of protein. General anemia of the tissues can hardly be expected to occur without involvement of the heart, kidneys and other vital organs. The theoretical damage to the kidneys from protein can well be balanced in some instances against the practical necessity of properly nourishing the diseased tissues. We believe it to be far more dangerous to allow a sub-acute nephritis patient to develop an increasing anemia on a diet low in iron, than to give a certain proportion of iron-containing, protein food.

Passing now to that large group of cases of so-called chronic nephritis with nocturia, high blood pressure and sometimes thickening of the peripheral arteries, the problem of therapy becomes the problem of individualization already mentioned. Such patients usually are long past the stage of simple hypertension, even though hypertension may have been the first symptom noted years before. These are difficult patients to treat at the best. If the symptoms or signs point to one of the three systems as being particularly involved, the best therapy would be to direct attention to the relief of this particular organ. A man with high blood pressure and persistent headache should be guarded against any type of emotional disturbance which would cause a rush of blood to the cerebral arteries; a man with pain in the cardiac area on exertion must have his life so directed as to put the least possible burden on the heart muscle. Nocturia should mean no fluid intake after 6 p.m. In most of these cases it has always seemed to us that the question of food was important, more from the quantity of total food ingested than from the quality. Many of these patients give a history of over-eating heavily. Many smoke to excess. Some, of course, have led exemplary lives. All physicians have seen this so-called chronic nephritis-high-blood-pressure-myocarditis syndrome in men who have never had any of the usual precursors of the symptom-complex. But when there does occur evidence of over-eating, the judicious thing to do is to cut down the total quantity. We have never restricted completely, any single article of food in such cases. We believe that a well-balanced, well-rounded diet containing anything the pa-

tient wants to eat in moderation will give much better results than any other dietary restrictions. We likewise believe that the restriction of the total diet should be only a part of the general plan of restriction of total activities, and that any value it might have in therapy must be derived from the restriction of general activities rather than from mere change in the food.

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“ST. BART’S”

By JOHN N. E. BROWN, M.B.

AFORETIME INSPECTOR OF YUKON HOSPITALS.

Of the hundreds of hospitals in United States, Canada, Great Britain and the Continent which the writer has visited, examined, and made note of, none impressed him from the historical standpoint like St. Bartholomew's Hospital, one of the Royal hospitals, in old London.

St. Bart's is located at Smithfield, memorable as the spot where, for their faith, English martyrs were burned at the stake. Hard by is Newgate where many criminals, some for rather petty offences, were hanged for their crimes in the presence of onlookers who paid a small entrance fee for admission to the hanging (which recalled to the writer his attendance at the first hanging in Dawson City, on invitation by a special printed, formal invitation from the High Sheriff.)

Close by St. Bart's was the Saracen's Head where Mr. Wackford Squeers made his headquarters. Here Nicholas Nickleby and his uncle met Squeers, and the hero engaged to go up to Dotheboys Hall as a teacher. It was at the Saracen's Head the poor young pupil victims were mobilized and it was from here the coach with pupils and masters set out for Yorkshire, the home of Squeers.

Eight hundred years ago St. Bartholomew's Hospital was founded—shortly after the Norman conquest. Its octo-

tenary was observed a few weeks ago. English and American medical journals have reports of the quaint proceedings at the old Priory Church, in the quadrangle and in the hospital itself, which we shall tell more of later.

This wonderful hospital was founded in 1123 by Prince Rahere, whose remains are deposited beneath his effigy in St. Bartholomew's Church adjoining the hospital.

Prince Rahere was King Henry I's minstrel and the court jester, so says tradition. It is related that after a time he became tired or satiated with the frivolities of the court and turned to a life godly and sober. He became permeated with a religious enthusiasm and sought companionship among the religious. It was the custom of the time to make pilgrimages to Rome, and Rahere was induced to go on one. While away he became very ill with some severe fever—malarial or typhoid, possibly. He evidently considered his recovery providential, for he made a vow that he would give his life to the founding of an institution for poor men. He stated that the apostle Bartholomew had appeared to him in a dream and intimated a desire to have a church to supply both physical and spiritual needs to the poor and indicated Smithfield as the site of such an asylum or monastery.

So when Rahere returned to London he appeared before the king, telling of his miraculous vision; whereupon the latter granted him a site within the King's Market; and in March, 1123, work on the first hospital began, and later on the Priory Church.

A few years ago the writer of this article visited the St. Bartholomew's Hospital and Priory and was shown by Mr. Hayes, the secretary, the original title-deed on parchment or vellum, given by the king to Rahere. At the same time Mr. Hayes showed the second charter, granted by Henry VIII to St. Bartholomew's and this is another story; our readers will remember that after Henry VIII was on the throne for a time he came into conflict with the Catholic Church, and one of his acts of opposition to this hierarchy was the abolition of all the monasteries in England. This edict, of course, included the monastery of St. Bartholomew's, the suppression of which left the poor of London in such a sorry plight that certain influential Londoners, headed by the mayor, petitioned the king

to restore St. Bart's. This he graciously consented to do and granted the second charter. Henry VIII's picture, done by Holbein, hangs on the walls of one of the great halls of the institution.

The writer of this sketch was told by Mr. Hayes that Sir Beerbohm Tree, who was playing Henry VIII at the Prince of Wales Theatre, had a day or so before sent his costumier down to inspect the picture in order to be able to produce a proper make-up for the actor.

No hospital visitor to London should fail to visit St. Bartholomew's; and no visitor interested in architecture should fail to see the Priory; for it is the oldest and best preserved of the early Norman churches. This bit of Norman work will interest educated Canadians particularly, since the main building of Toronto University—the alma mater of many of them—is the best and most beautiful specimen of Norman architecture in America.

As early as 1662 medical students were in the habit of attending the hospital; these embryo classes evolved into one of the greatest medical colleges in Great Britain. In London several of the medical schools seem to have developed out of the hospital. In 1726 an anatomical museum was built, since which enlargements and additions have been made—theatres, rooms for dissection, chemistry, botany and *materia medica*.

Then came laboratory after laboratory, ward units, operation theatres, pathology blocks and the like, which have become an integral part of the great institution. So here are seen the concrete manifestations of the religious, the scientific, the artistic spirit of the British people. Londoners are very proud of St. Bart's; and good right have they to be. Some of the greatest names in medicine are associated with this wonderful hospital; John Woodall, who discovered that the juice of the lime fruit would cure scurvy, in a plague of sailors and the undernourished poor; Pott, whose name is conserved in the fracture and the disease that bear his name; Harvey, the discoverer of the circulation of the blood; John Abernethy, 1787, one of the great surgeons attached to the hospital; and many others.

The octo-centenary celebration of St. Bartholomew's was fittingly observed in June last. The ceremonies began with a service in the old Priory Church, the only remaining building of Rahere's monastery. The front door of the hospital and its adjacent walls also, we believe, are part of the original building. The opening hymn was "Now thank we all our God" and the lesson: "Now let us praise famous men and our fathers that begat us."

At noon the guests and visitors assembled around the quadrangle. The Coldstream Guards stationed over the gateway blew a strong fanfare of trumpets; then appeared from the far end of the square a unique procession—one which had not been seen in the precincts for 400 years—a cross-bearer, thurifer, candle-bearers, and Roman priests. These were followed by thirteen canon regular of St. Augustine, selected from four Augustinian houses in England, two of whom were abbots. They chanted to Gregorian tunes, as they entered, their hymn in honor of St. Augustine, beginning:

*"Magne Pater Augustine,
Preces nostras suscipe;
Et per eas conditor
Nos Placere satage;
Atque rege gregem tuum,
Summum decus Praesulum."*

The scene was very spectacular. The canons wore cottas over their white habits, and birettas on their heads; the abbots wore black capes and gold pectoral crosses. Reaching the central fountain, the procession halted, a prayer was offered and there was pronounced a brief commemoration of St. Augustine. The procession then filed back along one side of the enclosure, chanting solemnly and subduedly, "*Deus misereatur nostri*," Psalm 67. Very simple, reverent, touching and pictorial, an onlooker describes it.

Then a gorgeously dressed herald, accompanied by Yeomen of the Guard, burst into the arena. The herald, in the name of the hospital president, the Lord Mayor, an alderman, treasurer and other governors, announced in a loud, strong voice that the celebrations were now to begin.

Then came a procession of the lame, the halt, the blind; fit subjects for the loving charity of the hospital to be, followed, after a pause, by Rahere on his return from Rome. He meets Richard, Bishop of London, in splendid pontificals, and traces on the ground the outline of the building he wishes to raise.

The final tableau, says *The Hospital and Health Review*, showed Henry VIII, burly and swaggering, (represented by Sir Arthur Bourchier) who in the midst of Lord Mayor, aldermen, courtiers, and the rowers of the State barge, carrying uplifted oars, granted the charter of the hospital as it is to-day, and restored the lands which had been alienated when the Priory of St. Bartholomew was suppressed.

The Welsh Guards closed by playing "O God our help in ages past."

Next day came the Bartholomew Fair with Tudor gallants, hooded friars and bearded magicians in costumes of the 16th century. Medical students entered into the spirit of the occasion and all was merry and joyful. The booths did excellent trade, selling "Sac and Petum of Virginia," "Toys, Trinkets, Gimeracks and Staconere," "Chattels and Phantasies." "Fairings for young and old" dispensed ham sandwiches aplenty. An astrologer cast the horoscopes of Anne Boleyn, Cardinal Wolsey, and Mr. George "Robie." There were whipping posts and stocks where many malefactors were made to suffer.

The day following there were amateur theatricals and tableaux in the Great Hall. The most interesting tableau was that showing a cripple girl being healed at Rahere's tomb. In addition there were: Rahere, the courtier; Rahere in a dream, being delivered from a dragon by St. Bartholomew; Harvey explaining the circulation of the blood to Charles I, and the hospital's war work.

Long life and prosperity to St. Bartholomew's!

Canadian Hospitals

THE HOSPITAL FOR SICK CHILDREN, TORONTO

In 1875, Mrs. S. F. McMaster, Miss Knapp, and a few other ladies of Toronto, decided to establish a hospital for children in the city, "on the voluntary principle," with the free help of leading doctors. During the previous year a contribution of some English coins was given toward the establishment of such an institution. Following report of this in the press, someone from Fergus remitted \$20 "for the sick little ones." Other small contributions followed. Thus encouraged, the founders rented No. 31 Avenue Street, a small, brick dwelling—the site of the present hospital—for \$320 per year. The personnel consisted of a matron, a nurse and a servant. The first patient was a small girl, suffering from scald. Nine young ladies endowed a cot in honor of this patient, by payment of \$100 per year. Two sick children were transferred here from the General Hospital. A young patient, Tom, so endeared himself to young ladies of Miss Neville's school that they decided to "keep a cot" for him. A child suffering from hip disease, was the first patient to be operated upon. She made a good recovery. By July, 1876, forty-four in-patients had been treated, and sixty-seven extern, at a cost of \$2,279.20. The receipts exceeded this amount. In June the hospital was moved to No. 206 Seaton Street, where its inmates were treated for two years. The committee of management consisted of sixteen ladies; a number of young ladies assisted.

In June, 1878, the hospital was moved to Elizabeth Street, near College Street; and was incorporated with the following trustees: Hon. Justice Patterson, Messrs. William Gooderham, Edmund Osler, and Hon. Chancellor Boyd. The new premises were opened with appropriate ceremony, Vice Chancellor Samuel Blake and Rev. John Potts taking part. As knowledge of the good work being done became known, contributions came in and helpers volunteered their services; by 1879 receipts and expenses had reached \$3,000 each; and during that year some 473 patients had been ministered to.

In 1881 the Ontario Government made a grant of \$100 to the hospital; and the Mayor and City Council paid the place a visit. In this year two bequests were made; one of \$500 from Mr. Samuel Smith, and one of \$20,000 from Mr. John Tucker.

In 1883 the hospital was honored by a visit from Princess Louise. By this time receipts and expenses amounted to \$6,000 each.

In the year 1882 there was built on Toronto Island The Lakeside Home by Mr. John Ross Robertson, who became the moving spirit in connection with the hospital. Its cost was \$5,000. In 1885 a wing was added and improvements made. In 1890 Mr. Robertson had the entire building remodelled. It is a most attractive structure, and perfectly serves the purpose for which it was built, its wide halls, verandahs, balconies, airy wards with sanitary accessories, and cheerful administration building making an admirable home for the children during the hot weather. To this invigorating spot the children are brought in early June each year, and remain until September.

In the fall of 1886, the children, upon returning from the Island, were taken to a new hospital in the city. Owing to the tumble-down condition of the mother hospital, the Notre Dame building, at the corner of Jarvis and Lombard Streets was rented and occupied until the summer of 1891; but this was only a make-shift. In 1887 it was decided to erect a new and up-to-date hospital on the old site on Elizabeth Street. Messrs. Robertson, J. J. Withrow and Dr. H. T. Machell formed the building committee. Mr. Robertson visited all the leading hospitals in the United States and Europe. The eminent Scotch architect, John Sellars, was engaged to prepare plans. When completed the plans were placed in the hands of Messrs. Darling and Curry, of Toronto, enlarged and modified to suit local conditions. The corner-stone was laid in September, 1889, by Mayor Clarke, in the presence of a "group of devoted, Christian workers, zealous philanthropists and worthy citizens." In two years it was completed. The cost was \$115,000. The city contributed

\$20,000; sundry subscriptions amounted to some \$37,000, a bequest to \$20,000. From 1886 to 1891 inclusive, Mr. Robertson's contributions alone amounted to \$21,000.

A school was established in the hospital in 1892. The Toronto Board of Education maintains the teacher.

About the year 1906, Mr. Robertson, greatly impressed with the work of Strauss in supplying pure milk for the children of New York, provided a pasteurizing plant for the hospital directly on the premises. In 1918, 110 gallons were pasteurized daily. A thousand bottles of special feeding were distributed each day, as well as 700 bottles of germless milk and cream. A milk laboratory was provided for the plant, for the preparation of feedings and the modification of milk for babies both in the hospital and in the city as well. A graduate in domestic science has charge of the milk station and instructs nurses in training in regard to all this line of work.

In 1912 the trustees established a dental clinic in the hospital, following which there was a marked improvement in the physical condition of the patients.

The hospital report for 1915 states that "at the end of forty years the hospital has grown at a rate unparalleled by any similar institution in the world. 26,108 children have been treated as in-patients, and 231,768 as out-patients." During the year 1914-15 2,338 in-patients were treated, forty-three per cent. of whom were cured, twenty-six per cent. improved, six per cent. unimproved, seventeen per cent. died, and eight per cent. remained in the hospital. The average daily cost of maintenance per patient was \$2.28 $\frac{1}{2}$, as compared with \$1.14 $\frac{1}{2}$ in 1904, and 76 $\frac{1}{4}$ cents in 1895.

The hospital has always had many orthopedic cases, necessitating a special department. The best surgical skill was obtained. A gymnasium was provided, and is utilized for the correction of functional deformities. Experts in massage treatment are employed for this class of patient; and nurses in training are given thorough instruction in this form of therapy. There is an appliance shop in this department in which the various apparatus needed for correction of deformities are manufactured.

When the value of X-rays began to be realized on this continent, the Children's Hospital was among the first to secure an apparatus and a competent radiologist. This department has always been kept up-to-date, and has been one of the special features of the institution. It has been of especial use in the diagnosis of tubercular conditions, conditions especially noticeable in many of the little sufferers treated here.

In 1910 Mr. Robertson erected a special building on the Island for the use of tubercular children. Its management is under the Heather Club. This place affords excellent advantages for this sort of case, and lessens the danger from infection to the other patients of the hospital.

In 1915 was established an infant and baby welfare service department. The cubicle system was introduced into the wards for the prevention of infections. This has proved a great success. Well baby clinics are conducted by the medical staff and nurse specialists. Here mothers are taught the best methods of infant feeding, and how to properly bathe and clothe their children. Nurses in training receive tuition in this important branch of child welfare.

In 1916-17 the light, heat and power plant was completely renovated. A refrigerator system was installed capable of producing the equal of twelve tons of ice per day. One thousand pounds daily are required in some of the wards.

In 1918, the average days' stay was 14, as compared with 20½ the previous year. In this year's report it is noteworthy that a special laboratory was given to the hospital through the generosity of Mrs. W. C. Teagle. This makes it possible for the staff to make important special studies in nutritional disturbances.

On May 31st, 1918, John Ross Robertson died. Sir Edmund Osler, who succeeded him as chairman of the trust, says that Mr. Robertson's dream was of a great hospital, able to meet without embarrassment every demand of the sick children in this province. Everything of which he died possessed ultimately goes to the hospital. "This," says Sir Edmund, "is the most princely benefaction to the public that is chronicled in the history of Canada."

BRIEF SUMMARY OF THE HISTORY OF RIVERDALE ISOLATION HOSPITAL, TORONTO

Riverdale Isolation Hospital dates back to the year 1891, where the old House of Refuge situated on the east side of the Don in Riverdale Park, was made use of as a hospital for the care of patients suffering from diphtheria and scarlet fever.

Dr. Norman Allen was Toronto's medical officer of health at that time. Dr. A. R. Pyne, Dr. Walter McKeown and Dr. W. F. Bryans were members of the Department of Public Health staff. Dr. Gilbert Tweedie was appointed as superintendent of the hospital.

The Sisters of St. Joseph took charge of the nursing. Among them were Mother Juliana, Sister St. Felix, Sister De Sales, Sister Usemia, Sister Atraeta and Sister De Metia. In the year 1893 St. Michael's Hospital was about completed; the Sisters of St. Joseph severed their connections with the Isolation Hospital to open St. Michael's Hospital, and organize the nursing in that institution.

In November, 1892, owing to an epidemic of smallpox in the city of Toronto, a shack was built within a short distance of the Isolation Hospital that would accommodate fifteen smallpox patients. (This shack was completed within eighteen hours' time).

In 1893 the centre buildings of the present Isolation Hospital were built, giving hospital accommodation for ninety patients. The first floor of the centre building included the executive offices, superintendent's quarters, also rooms for the superintendent of nurses. A disinfectant station was built the same year, and a sterilizer plant installed.

Scarlet fever patients occupied the north wing of the building overlooking the Park. Diphtheria patients occupied the south wing of the building. A courtyard fifty feet wide divided the north wing from the south wing.

Miss Jennie Chaplin, a graduate of the Hospital for Sick Children, who had afterwards taken a post-graduate course in one of the large hospitals in Chicago, was appointed as superintendent of nurses.

The late Dr. Fred Fenton was the first house surgeon in the Isolation Hospital. Dr. Sheard was appointed medical officer of health the same year.

In 1894 a training school for nurses was established in connection with the hospital. The origin of the training school was due to the necessity of having trained and skilled nurses for the care of patients suffering from communicable diseases, and for the purpose of affording those desirous of becoming professional nurses a systematic course of both theoretical and practical work in this particular branch of nursing as well as in all medical nursing. Such experience could not be obtained in any other hospital owing to the fact that patients contracting a communicable disease were immediately transferred to the Isolation Hospital. In order to make the training course more complete, affiliation was arranged with the General Memorial Hospital, New York, for experience in surgery, gynecology and operating room service.

In 1895 the old House of Refuge was demolished and burned by order of the City Council.

Miss Jennie Chaplin, superintendent of nurses, resigned in 1899. She was succeeded by Miss Annie Montgomery, who only remained in office until 1900. In January, 1900, Miss Kate Mathieson was appointed as superintendent of nurses.

In 1901 the old smallpox shack was still in use. Through the efforts of Alderman Lamb and Alderman Crane, both members of the Local Board of Health at that time, plans were submitted for a building on the east side of the Don north of Winchester Street, at a cost of \$6,000.00. This building, known as the Swiss Cottage, was completed in November, 1902. On December 10th four patients were transferred from the old shacks to Swiss Cottage Hospital. A few weeks later the shack was burned down. When the Swiss Cottage was completed, \$100.00 was allowed for equipment and furnishings. That seems incredible, but poor me was considered to have most extravagant ideas for exceeding that amount.

The Department of Public Health in 1902 extended to the University of Toronto the privilege of allowing medical students in their fourth year to attend clinics at the Isolation

Hospital. The interest and appreciation displayed by large groups of medical students attending these clinics every year leads me to believe that the value of clinical teaching in communicable diseases cannot be over-estimated.

In May, 1904, the south building of the Isolation Hospital was completed. On May 4th the formal opening was held. Representatives of the City Council were present, and also of the Provincial Board of Health, as well as many of the city doctors. One of the city officials made the statement on this occasion that with this additional wing furnishing accommodation for sixty-five patients, the city of Toronto would be in a position to give hospital care to all infectious patients for the next twenty years. Alas, how far from the mark! Within four years' time the hospital accommodation was not sufficient to meet the needs of the city. Every available space was made use of, and always a waiting list to fill the vacancies as they occurred.

In 1909 contracts were let for the erection of the north building, which is at present occupied by scarlet fever patients. The building was not completed until July, 1911, the year following after Dr. C. J. Hastings' appointment as Toronto's medical officer of health.

Since the year 1911 many additions and improvements have been added to the hospital. Among the most important ones are: a new steam laundry plant, the centre building and south wing being remodelled; an operating room installed in the diphtheria building, diet kitchen for teaching purposes enlarged, the nurses' demonstration room enlarged, additional store rooms, and the main kitchen enlarged and equipped. Within the past year the operating room has been installed in the scarlet fever building, with modern equipment, also bed pan and utensil sterilizers in the different sections of the hospital.

The work of the training school has also advanced with the rapid growth of the hospital service. As this is the only hospital for communicable diseases in Canada conducting a training school for nurses, it did not have traditions handed down to be followed or lived up to. The training school had its own traditions to build, its own courses to map out.

It is gratifying to those interested in the work of the hospital to know that in the face of many difficulties the record of the training school is one of high standards and advancement.

The hospital was registered in the state of New York in 1904, the training school having met the requirements set by the regents of the University of the State of New York, thus enabling our nurses who are engaged in the various branches of nursing activities in New York to become registered nurses.

The Alumnae Association of this hospital was organized in 1905. The object of the Association is the promotion of unity and good feeling among its members and the advancement of the interests of the nursing profession. The Alumnae Association has been the means of interesting its members in the activities of the various nursing organizations, and also to prepare its members to exercise the rights and privileges of citizenship, and in public welfare work. The establishment of a fund for sick nurses and the awarding of scholarships are now under consideration.

In 1910 our affiliation with the General Memorial Hospital, New York, was withdrawn, owing to that hospital giving over its services to cancer research work. Affiliation was arranged the same year with the Women's Hospital, New York, for a six months' course in surgery, gynecology, operating room and clinic work, also obstetrics. The course includes lectures and demonstrations in surgical, obstetrical and gynecological nursing. This affiliation has proved most satisfactory.

The centralized lecture courses arranged with the University of Toronto in 1918 have been of the greatest benefit to the pupil nurses. 136 lectures have been given by different members of the Faculty during the past year. The outstanding features of this teaching are the establishment of a uniform course of instruction for the hospitals that are taking advantage of it. The instruction given by members of the Faculty stimulates a keener interest on the part of the pupil nurse than when lectures are received in the home school.

A very comprehensive course of lectures in medical social service has been arranged by the social service department

of the University of Toronto. This course is of distinct advantage, as it is not possible for all the hospitals to give each pupil experience in district work.

The Department of Public Health of the city has arranged to give pupil nurses who are taking the social service course two months' field work, where the pupil nurses receive the practical experience as well as the theory which to them is invaluable. This experience prepares the pupil nurse for conditions which she will meet in the homes after graduation when engaged in private nursing. Public health nursing has become one of the strongest forces in reaching into the homes of the masses. This has placed heavy responsibilities upon those accountable for the training of nurses. It has always been our aim to have our nurses prepared for any of the various courses open to the graduate nurse.

During the recent war twenty of our nurses served overseas. We are thankful that they all returned to Canada safely, and to know that during their years of service to their king and country they upheld the high ideals of the nursing profession.

The school has now 140 graduated. Sixty-three are married; the remaining seventy-seven are engaged in the various branches of nursing, such as public health, social service, institutional nursing, private duty nursing, and superintendence of hospitals.

Rev. Gilbert Tweedie, M.D., born January 12, 1828, in Dumfriesshire, Scotland, attended the parish school in Annan until he entered the University of Edinburgh at the age of sixteen; then taking up the double course of theology and medicine, with the intention of entering the foreign field as a missionary. It was at this time that Sir James Simpson discovered the use of chloroform as an anesthetic. Dr. Tweedie assisted Sir James Simpson with his experiments. It was with pride that the Doctor related his experience as being the first one to use chloroform, and that on Sir James Simpson, who wanted to know the effects of the anesthetic upon himself. Dr. Tweedie was present at the first operation performed with the use of chloroform.

Coming to Canada in 1849, he completed his divinity course, and did pioneer missionary work in Victoria County,

where he was also superintendent of schools. He was obliged to retire from the ministry, owing to throat trouble in 1858.

Again taking up his studies, he graduated from Victoria College of Medicine in 1860. He practised in Victoria and Kent Counties until 1891, when he moved to Toronto and was appointed superintendent of the Isolation Hospital.

Dr. Tweedie's sterling qualities will always be remembered by those who have been associated with him. One of his outstanding characteristics was his loyalty to the members of the medical profession. His kindness to the poor and the personal interest he had in all his patients endeared him to the hearts of many. He resigned, owing to ill-health in 1905. He died on 23rd August, 1916.

Dr. Robert Woodhouse succeeded Dr. Tweedie. He was afterwards appointed medical officer of health of Fort William. At present he has some position in connection with the Provincial Board of Health.

The following are the medical superintendents of the Isolation Hospital since Dr. Tweedie's time: Dr. Robert Woodhouse, 1906-1908; Dr. William Johnston, 1908-1909; Dr. Fred. Hazelwood, 1909-1911; Dr. Marchmont B. Whyte, 1911-1920; Dr. Cecil Rae, 1920.

EAST END HOSPITAL PROJECT ENDORSED AND PLANS FORMED

Definite plans for the launching of a campaign to collect funds for the erection of a 400-bed hospital east of the Don River at an ultimate cost of \$500,000 were heartily endorsed at a meeting of the Toronto East General Hospital Association in the Riverdale Technical School, Greenwood Avenue, on September 26.

On the recommendation of the Organization Committee in charge of the project, it was decided to ask the City Council to consider the purchase of an 8½-acre site at the south-east corner of Sammon and Coxwell Avenues at a cost of from \$100,000 to \$115,000. Members of the City Council who were present stated that the city would undertake to provide a site when those behind the scheme had raised \$250,000 toward the erection of the building.

The tentative proposals placed before the meeting call for the construction, as soon as the funds are available, of a three-storey, 200-bed wing at a cost of \$250,000. It is proposed that accommodation be provided as follows: fifty public beds, 100 semi-private beds at \$21 per week, and fifty private beds at \$30 per week.

Methods of financing, location of site and the date of campaign for subscriptions were the principal topics of discussion at last night's meeting. It was agreed that direct appeals would be made to the citizens living east of the Don for subscriptions, on the understanding that moneys secured would be considered as donations and not investments. Objection was made that the site recommended was too costly, and that similar property on one of the other corners at Sammon and Coxwell avenues could be secured for \$85,000. A motion to refer the site recommendation back to committee was defeated, however, when members of the Site Committee explained the reasons for their decision.

Considerable discussion arose as to whether the financial campaign should be held this fall or next spring. Several speakers urged that no time should be lost, while others held that it would not be possible to organize a thoroughgoing plan of campaign before next spring.

Ultimately the meeting voted unanimously to authorize the committee to arrange for the campaign "as soon as possible," on the understanding that an effort would be made to launch it before Christmas, probably during November.

The personnel of the committee in charge is as follows: Chairman, J. H. Harris, M.P.; Vice-Chairman, John L. Bolton; Advisory Counsel, E. B. Ryckman, K.C., M.P.; Secretary, A. Julian Mockford; Treasurer, R. O. Darling; Assistant Secretary, E. J. Deacon; and, Executive, Drs. J. Y. Ferguson, E. A. Macdonald, J. E. Knox, W. F. Plews, and Messrs. Joseph Price, Isaac Pimblett and John Walshe.

Among those who spoke in favor of the project were Controller Hiltz, Ald. Shields, and Ald. Summerville, ex-Ald. Sanderson, Principal Michell of Riverdale Collegiate, and several members of the committee.

SATISFACTORY FINANCIAL REPORT FROM ROYAL ALEXANDRA HOSPITAL, EDMONTON

A most satisfactory report on the financial situation was received at the meeting of the Hospital Board of the Royal Alexandra Hospital, Edmonton, on September 28th. The chairman of the finance committee, W. H. Speer, recognizing, as he said, that this situation is largely due to the work of their medical superintendent, Dr. H. S. Smith, made the proposal that the Board consider the question of increasing the salary of that official.

In order to divert the subject into the proper channel, A. Farmilo said that he would propose that it be referred to the executive and finance committees, and the motion was carried.

It was stated that the deficit on the working of the hospital for August was \$6,300, but this was due largely to the fact that certain surgical supplies would have to be obtained which would not be wanted again for some time, also that the number of patients had been lessened. The deficit for the year up to the end of August was \$41,000, whereas the estimated deficit for the year was \$80,000.

Mr. Speer remarked that a year ago the estimate for the year was \$120,000, and the city commissioners reduced this to \$110,000, and in turn the medical superintendent, by his management, had further reduced the sum to \$80,000. This year the estimate allowed by the commissioners was \$80,000 and, so far, the deficit amounted to only \$41,000.

Mrs. Melrose, Mrs. Ross, the chairman W. T. Henry, and W. H. Speer, were appointed as a committee to take up the subject of providing furnishings for the Isolation Hospital and the Nurses' Home.

The medical superintendent reported that the Isolation Hospital would shortly be ready for plastering, but he did not think that it would be ready for use until the New Year.

He stated that the walls of the laundry building were in progress of construction. The excavation for the boiler house, he also said, was now proceeding, but he pointed out that the work would have to be hastened if the new buildings were to be supplied with heat from this source.

The executive committee was given the task of considering the question and making recommendation on the subject

of how the advantages of the city hospitals, which include the Royal Alexandra and Isolation Hospitals, can best be brought to the attention of the public. The idea is not to organize a regular publicity campaign, but, in the words of the medical superintendent, Dr. H. S. Smith, who brought the matter to the attention of the Board, it is to inform the public upon what is now ready and waiting for their service in the new and enlarged buildings. A number of ways were suggested which might aid in the work, such as the erection of signs, the use of picture postcards in the hospitals bearing views of the building, and the issuing of pamphlets describing the nature of the hospital buildings.

A. J. Farmilo alluded to the necessity of inducing the public in general to utilize the Isolation Hospital, otherwise its value would be wasted. The community, he said, had made a great effort to provide the money for the building, and every possible use should be made of it.

On the motion of Ald. D. Knott, seconded by the Rev. Comyn-Ching, the matter was referred to the executive committee.

Mrs. Melrose, delegate to the conference of the Provincial Hospital Association, held at Calgary, read an interesting report upon the work done, and informed the Board that their medical superintendent, Dr. Smith, had been elected as President of the Association for the ensuing year, and Mr. S. V. Davis, the Board's secretary, as Secretary-Treasurer to the Association.

Dr. Smith also furnished some details of the meetings.

G. Beart, who was the Board's representative at the conferences of the American College of Surgeons at Edmonton, sent in an extremely well-considered report on the proceedings, which contained a number of suggestions of value to the Board.

The reports were received and the delegates thanked for their work.

The medical superintendent, Dr. Smith, was appointed as the Board's representative to the conference of the American College of Surgeons, to be held at Milwaukee, if circumstances are such that he is able to attend.

It was stated that the draft agreement which the Board proposed to enter into with municipalities in respect to the care of patients, and hospital charges, had been referred to the Provincial Minister of Health, and did not meet with his approval. The subject was referred to the executive committee for them to take up with the Minister.

THIRD HOSPITAL OPENED BY RED CROSS SOCIETY.

The third hospital to be established in New Ontario by the Ontario division of the Canadian Red Cross Society was officially opened early in September at Dryden, Ont., by Mayor W. S. Pitt, with the assistance of the members of the council, the local clergy, David Kennedy, M.P., Miss Maud Wilkinson, of Toronto, director of nursing service for the Ontario Red Cross, and Miss May Morley of the Toronto General Hospital, who are in charge of the new institution. In the principal address of the day, Mr. Kennedy expressed the view that the general public should be taxed for the maintenance of hospitals in the same way that they are for schools.

THE BRITISH HOSPITALS' ASSOCIATION.

The last meeting of this association was held in Sheffield, a strategic hospital centre just now when many voluntary hospitals have their backs to the walls.

Sheffield has a Joint Hospitals Council which represents most of the city's varied interests—commercial, industrial, educational—"irrespective," (as the *Hospital Review* puts it) "of social considerations, harnessed to ensure active recognition of the fact (and its accompanying obligation) that the hospitals are primarily intended for the unemployed and for the sick poor, and that they must secure regular and unfluctuating support."

Substantial results have accrued from a scheme whereby the employee gives one penny in each complete pound of his earnings, and the employer adds not less than one-third to the total of his employee's contributions.

NEW SUPERINTENDENT FOR KINGSTON GENERAL HOSPITAL

Announcement was made on Sept. 22nd by the board of governors of the Kingston General Hospital, that F. Taylor, business manager of St. Luke's Hospital, Ottawa, had been appointed superintendent to take the place of Dr. A. E. Ross, M.P., who resigned.

B. C. ASSOCIATION

The British Columbia Hospital Association meets in Penticton in August.

FIRM GETS CONTRACT

W. M. Sutherland and Co., Limited, Toronto, were on July 16th, awarded the contract for the general construction of the new St. Mary's Hospital at Kitchener. The contract price was \$258,000.

CENTRAL BOARD OF APPEAL.

A recent announcement was made by the Hon. Dr. Beland, Minister of Soldiers' Civil Re-establishment, that Col. (Dr.) C. W. Belton will act as permanent chairman of the Central Board of Appeal. Another member of the Board is Capt. (Dr.) Bruce Wickware, of Ottawa, formerly superintendent of the Moose Jaw General Hospital.

INSURANCE COMPANY AIDS HOSPITAL

A grant of \$5,000 has been made to the building fund of the new St. Mary's Hospital by the Economical Mutual Fire Insurance Company of Kitchener. The hospital in question has been started and when equipped will be worth half a million. Catholic societies have raised all but \$50,000, and a campaign is in progress to raise that amount from the citizens generally.

Book Reviews

The Hospital Library, comprising articles on Hospital, Library Service, Organization, Administration and Book Selection, together with Lists of Books and Periodicals suitable for Hospitals, by Edith Kathleen Jones, General Secretary, Division of Public Libraries, Massachusetts Department of Education, formerly Librarian, McLean Hospital, Waverly, Mass., Chicago: The American Library Association, 78 East Washington Street, Cloth, \$2.25.

Many hospitals are introducing libraries, either on the unit or group system. The history of the movement, how to organize a library, support it and carry it on are interestingly described in this book. Also there is a fine, long, classified list of books suited to hospital patients. All book lovers and librarians, as well as hospital folk, will enjoy this volume.

Home Nurse's Handbook of Practical Nursing. A Manual for use in Home Nursing Classes, in Young Women's Christian Associations, in Schools for Girls and Young Women, and a Working Textbook for Mothers, Practical Nurses, Trained Attendants and all who have the responsibility of the Home Care of the Sick. By Charlotte A. Aikens, formerly Director of Sibley Memorial Hospital, Washington, D.C. Third edition, thoroughly revised and illustrated. Philadelphia and London: The W. B. Saunders company. Canadian Agents: The J. F. Hartz Co. Limited, Toronto. 1923. Price \$2.00 net.

This book deals with home nursing; not the more elaborate technic of hospital practice—a guide to the home keeper who desires to fit herself to do the best for the health of her own family. It also may be used as a working text-book for practical nurses and trained attendants who desire to help the doctor in the home sickroom. Special attention is given to care of babies and to maternity-nursing. The book can be grasped by the average girl who has reached the sixth or seventh grade.

Applied Psychology For Nurses, by Donald A. Laird, Assistant Professor of Psychology, University of Wyoming; Lecturer in Nursing Psychology, Ivinston Memorial Hospital School of Nursing. Illustrated. The J. B. Lippincott Company, Philadelphia, London and Montreal. Price \$2.50.

Readers of *The Trained Nurse* are familiar with the literary work of Laird on psychology. It has been most helpful. Many have been waiting for this child of Laird's brain. It is dedicated to the nurse who would understand her own mental life, and to the patient whose mental life should be understood by the nurse. The author tells the cause and nature of ill-health, something about the feeble-minded, how to use suggestion, what should be expected from psychology in medicine and nursing, the basis of human behavior and the biological foundations of it in the origin of man's needs. The book tells of the use and abuse of thought, and how behavior indicates mental activities. The temperaments are discussed and the author points out how bad temper runs in families.

This is a worth-while book, not only for nurses, but also for doctors, most of whom have not had the opportunity of studying psychology at college.

The Infant and Young Child. Its Care and Feeding from Birth until School Age. A Manual for Mothers. By John Lovett Morse, M.D., Edwin T. Wyman, M.D., and Louis Webb Hill, M.D. Illustrated. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co. Limited, Toronto. Price \$1.75 net. 1923.

This book is rather unusual in the variety of subjects discussed. The section on care and training is very good. There are so many different opinions upon the feeding of children from two to six years of age that one does not expect agreement with all theories advanced. Each author is more or less opinionated. Recognition of malnutrition in children means corrective measures in time. This book contains some common-sense observations on malnutrition. A mother can surely glean good ideas from this book, although it is not necessary for her to accept it as an infallible guide in every phase of her child's life.

The Effects of Radium upon Living Tissues, with special reference to its use in the Treatment of Malignant Disease.

By Sidney Forsdike. 72 pages with 42 illustrations (included in nine plates). Price 5/-. This is the Jacksonian Essay and gives a history of radium, describes its action on the living cells and animal tissues (experimental), effects on malignant cells, and growths, with technique of treatment.

Institutional Household Administration by Lydia Southard, B.A., House Director of Whittier Hall and Instructor in Institution Administration, Teachers College, Columbia University, New York. 91 illustrations. Philadelphia, Montreal and London: The J. B. Lippincott Company. Price \$2.00.

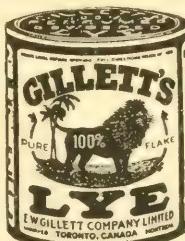
This book should find favor in schools where courses are given for trained housekeepers. There is in it much material of value for any one interested in this phase of work in any school or institution.

The book is interesting as well as instructive for institutional housekeepers and instructors, and for the woman who manages her own home. It is clearly and concisely written and is very well indexed for quick reference.

Principles of Home Nursing by Emma Louise Mohs, R.N., A.B., Member of the Department of Hygiene and Public Health of Northeast Missouri State Teachers College, Kirksville. Illustrated. Philadelphia and London: The W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Limited, Toronto. 1923. Price, \$2.00.

The principles underlying home nursing are simply, carefully, accurately, and completely presented in this book. Its merit as a text-book, for college students planning to teach, or to take charge of homes of their own, is self-evident. The book teems with valuable information which will aid in relief in illness and provide the mother with an accessible guide in times of emergency and stress. The mother with this knowledge will be able to intelligently interpret the physician's orders. It is an excellent little book.

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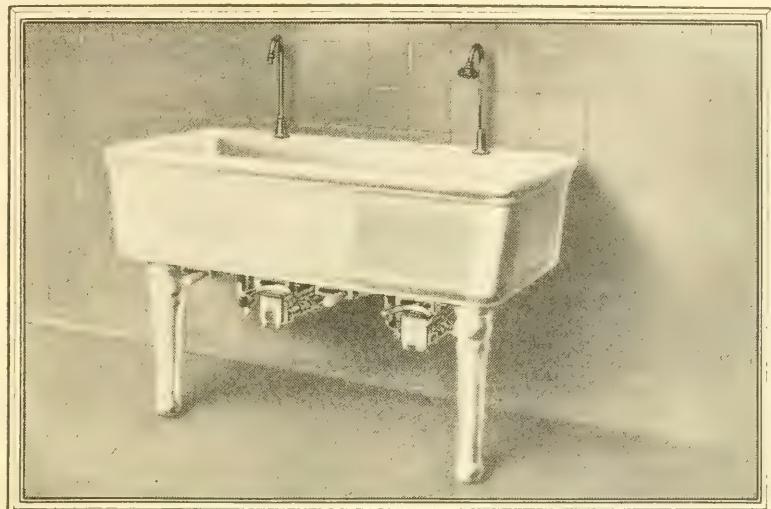
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No matter how progressive we are, most of us are inclined to cling to methods that we have used or that have been used by the people surrounding us, until new methods are so forcibly brought before us that there is no shadow of doubt in our minds that we should adopt them. The physician, on account of his training and general advanced trend of thought is usually the first to adopt new ideas if he is convinced of the soundness of their underlying principles. Fuel oil burners have been passing through their infancy—in fact out of very many types of machines built, the majority are still in the experimental stage—there are very few with the exception of the Hack Fuel Oil Burner who have any successful record of past operation. Given the right type of oil burner there is no comparison between oil and coal as fuel—the advantages are all on the side of oil. Oil gives an abundance of absolutely uniform heat—there being no fluctuation as in the case of a coal fire. There are no harmful combustion gases in oil burning, such as coal produces. Many people think that because their furnace joints are tight that the air in the house is not becoming contaminated with coal gas. Every time the furnace door is opened to replenish the coal fire, sulphur gas is liberated, which is most injurious to health.

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The principle of the Hack Fuel Oil Burner is altogether different from any other type. Oil is pumped from a non-gravity tank under pressure and is met by a heavy air blast which blows the oil into the furnace, thoroughly atomized and in a condition that gives complete combustion—herein lies the secret of the absence of carbon and soot. The retention of heat in the furnace is accomplished by a lining of fire brick which after an hour or so of operation becomes thoroughly impregnated with heat; with a hot water system the water will be kept hot for a period of from four to six hours, and with hot air from two to three hours—this feature means a big saving of fuel. Oil burning as typified in the Hack Fuel Oil Burner has proved itself to be absolutely dependable and many steps ahead of coal as fuel.

(See page 1 for illustration).



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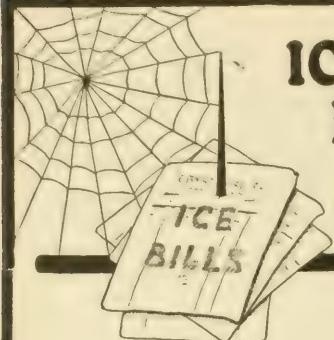
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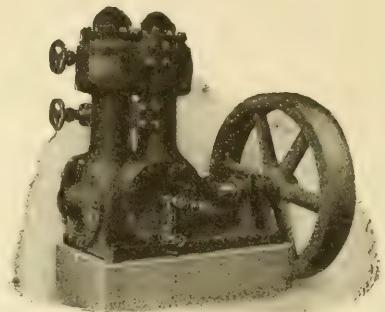
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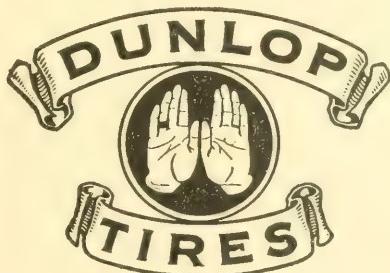
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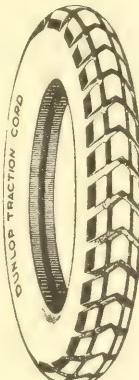
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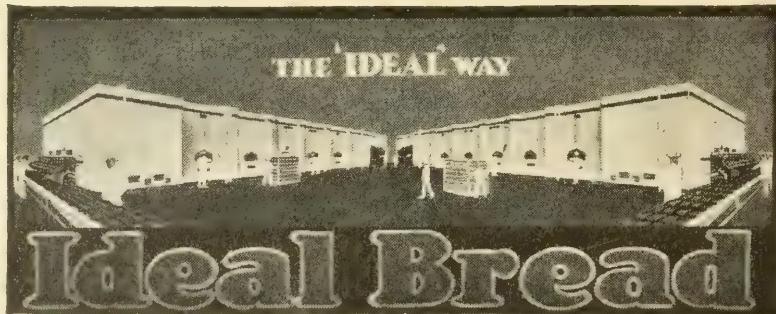
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THE HOSPITAL WORLD

Vol. XXIV

Toronto, December, 1923

No. 6

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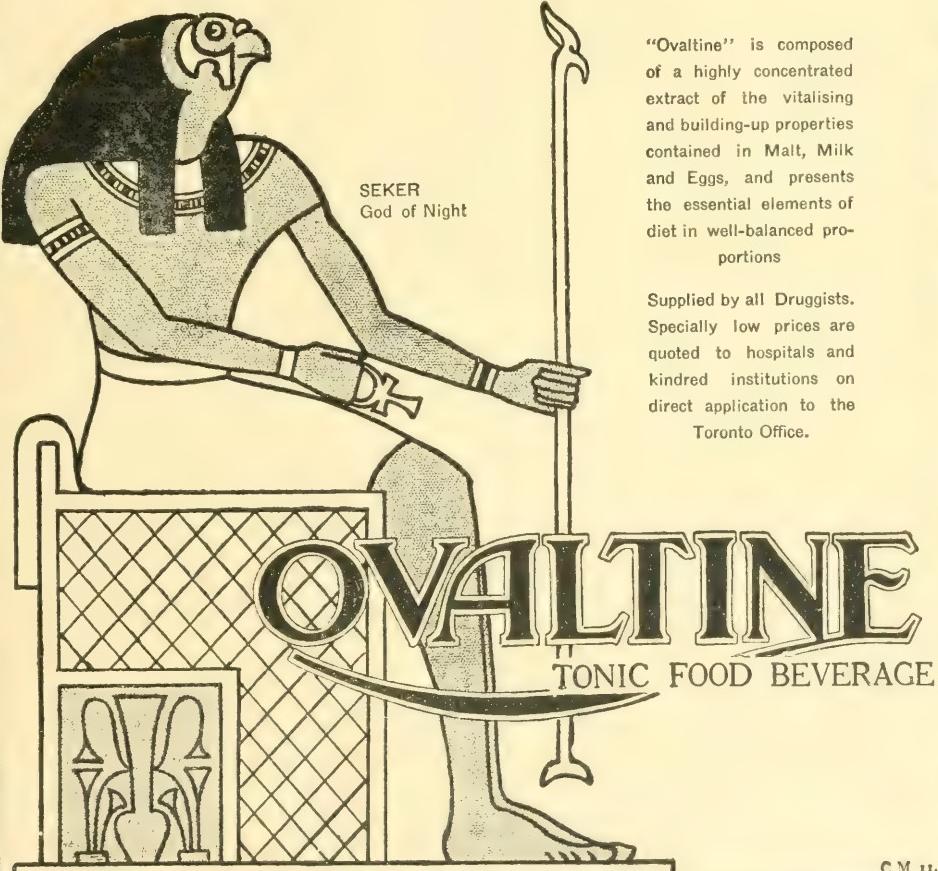
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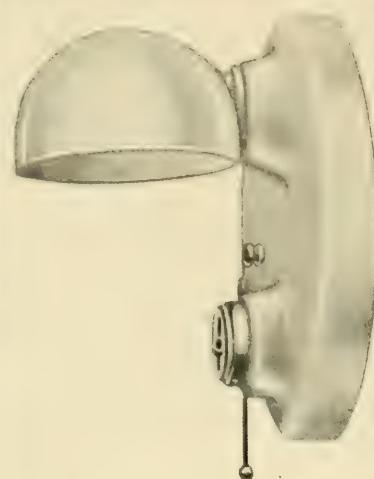
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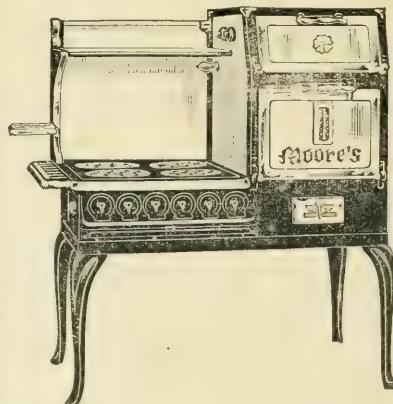
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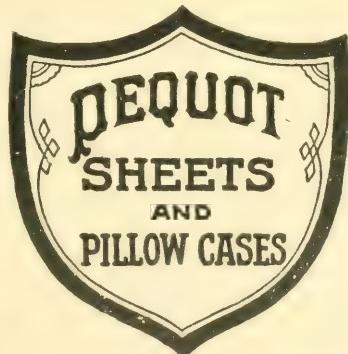
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The Hospital World

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Editorial

American Hospital Association

This association met in Milwaukee Oct. 29th-Nov. 3rd. The aim of the administrators has been to collect and present a maximum amount of the best information and a concensus of opinion on the live and pressing hospital problems.

The exposition of hospital exhibits—commercial and non-commercial—covered almost two acres. There was an exhibit of floor plans of 600 hospitals arranged according to types and sizes. Fifty-one plans received in the prize contest conducted by the *Modern Hospital* were shown; as well as a selected group of plans of hospitals and sanitariums for tuberculosis. The committee for hospital construction, equipment and maintenance, had a booth for the purpose of giving service through discussion, information and advice, where all interested might talk their problems over. Last year there was an instructive special report on floors. A second report was made this year and specimens tested and described.

There was also on exhibition a complete model of a regular hospital kitchen, diet kitchen, bakeshop and accessories. They were well worth studying. An educational exhibit of occupational therapy craft work was also to be found, wherein articles useful and artistic, made by patients, were placed for inspection and study.

Canadians were especially proud to find that representatives of the Royal Victoria Hospital, Montreal, gave a continuous practical demonstration of their methods in the treatment of diabetes by insulin.

From the library and service bureau section there were distributed bibliographies on all sorts of hospital questions. There were 3,000 requests for such information last year at Atlantic City.

Demonstrations were given of the up-to-date methods of heart clinics, making clear approved means for the prevention and most effective procedures in the relief of cardiac affections. This is important when it is remembered that the mortality from heart diseases is rising rapidly.

A committee on dispensary development in New York displayed various findings and conclusions they have arrived at after years of intensive study of the problem.

The American Medical Association presented facts and results of the studies on the relation of hospitals to medical education.

Social service workers from all sections of America were present to discuss various phases of the work in which they are engrossed. They made

a statistical exhibit, which, in spite of its dry figures, will be found to be both instructive and suggestive.

On October 26 and 27, the Chicago hospitals entertained all visiting delegates with a programme of demonstrations in various hospitals. They were transported through the Windy City by special motors.

Reports of committees of canned fruits and vegetables, on renovation of gauze, cleaning, and other work were received.

Canada was well represented.

The Sheffield Hospitals

A contemporary informs us that Sheffield (England) has five voluntary hospitals—united in their appeal, unhampered by redundant effort and working to a common end. Here is a lesson for some of our Canadian and American cities, with their spasmodic, unsystematic, individual, capricious efforts to maintain their institutions.

Three years ago the Sheffield hospitals found themselves with a shrinkage of private subscriptions and an irreducible annual expenditure of £120,000; so they combined to meet the dangers threatened by declining trade and unprecedented unemployment.

A new policy was adopted by the Joint Hospitals Council with a view to more democratic control; virtually every force in the city's civic, educational, industrial and commercial life, irrespective of social considerations was harnessed to ensure active re-

cognition of the fact (and its accompanying obligation) that the hospitals are primarily intended for the unemployed and for the sick poor, and that they must secure regular and unfluctuating support.

By the new scheme, the employee gives one penny in each complete pound of his earnings; the employer adds not less than one-third to the total of the employee's contributions. In return unlimited numbers of letters of introduction are placed at the disposal of each contributing establishment, to be used only for the workmen and their dependents. Hospital treatment is promised in so far as beds are available; medical urgency is the only condition of admission. This general principle is made to apply to shopkeepers, workers in union establishments, and even to neighboring towns. Arrangement has been made with the Poor Law authorities by which urgent cases for which no bed is available in the voluntary hospitals may be admitted to a Poor Law hospital, at the expense of the Joint Hospitals Council.

Toronto, with its annual big deficits, and other Canadian cities which find difficulty in financing, might well consider the Sheffield plan.

Hospital Libraries

Hospital libraries in America sprang into existence in 1904 where one would expect they would—at or near Boston. One was the McLean Hospital for Insane, the other in the Massachusetts General. It was discovered in the former that the right sort

of books helped toward the recovery of mental ailments; in the latter that they acted like tonics and sedatives.

When the war supervened, then it was seen how important a part books played in the entertainment of convalescent patients. This gave the library movement a great impetus. Now we hear of the therapeutic value of books, just as a few years ago we heard of the value of occupational therapy.

The hospital library may contain books not only for patients, but for nurses, doctors and attendants. One librarian may be in charge—on part or full time duty, depending on the size of the hospital and the amount of work to be done. If the hospital is unable to pay for the full time service of a well-trained librarian, one of the hospital officers or employees may be placed in charge, carrying on his own work and the library work. The principle qualifications for a hospital librarian, according to the author of *The Hospital Library*, are health, dignity, maturity, tact and a large amount of social service spirit. In some hospitals the social service department assumes charge of the library work.

The library room should be bright, attractive and comfortable, with easy chairs, a fireplace and some pictures. It should be a place where patients may look over books and converse when not disturbing other readers.

Miss Kathleen Jones says women want love stories and men, western, detective and adventure stories. She advises that stories containing characters who are insane, degenerate, or epileptic should be ex-

cluded. Stories of suicides, morbid and depressing novels, tales of unhappy childhood, marital infelicity, and physical deformities which warp a man's nature should be debarred; also those which end unhappily. Erotic stories, and those discussing sex problems, ghost stories, self-analytical novels, or those which contain gruesome or bloody details or which depict horror are likewise taboo. This author puts the ban on most books on psychology, religious discussion, law, medicine, and mental hygiene, unless the patient's physician passes upon them.

There are plenty of clean, charming, entertaining stories—fine, strong, thoughtful novels; detective stories (not psychic) which dwell upon the skillful raveling of the mystery (not on the details of the preceding crime), books with pictures, on travel, history, biography, poetry, essays, out-of-door books on trees, flowers, birds, animals and scenery—all this sort are recommended by the author of *The Hospital Library*.

Such well known authors as Longfellow, Whittier, Tennyson, Dickens and Thackeray are admitted as a matter of course. Among the newer and less known authors Miss Jones names Butler (*Pigs is Pigs*), Mrs. Mary Andrews, Bangs, Wister, Lincoln, Bacheller, D. D. Wells, J. J. Bell, Birmingham, C. D. Stewart, Clouston, Bessie Hoover, H. Hall, Leacock, Janvier, Fedden, Mrs. Gillmore, Mrs. Vorse, Stockton, R. H. Davis, Grenfell, Miss Wilkins, Mrs. Wiggin, Dorothy Canfield, Laura

Richards, Gale, Van Dyke, Henry, Jacobs, Conrad, Merriman and many others.

We suggest that all our Canadian hospitals introduce the library idea.

Books for hospital libraries should have their covers shellacked, should be fumigated and exposed to sunlight (when necessary) and kept in thorough repair.

Hospital librarians should wear gowns when at work and also gloves. If they do not use gloves, they should wash their hands *frequently* with soap and in running water.

History of Toronto Hospitals

The Dominion Publishing Company of New York and Toronto have published a history of Toronto in three large volumes. Jesse Edgar Middleton is the editor-in-chief. A score or more of special writers contribute articles on the subjects in which they are particularly interested. "The Hospitals of Toronto" is the subject treated by Dr. John N. E. Brown, one of the editors of THE HOSPITAL WORLD. It is this article perhaps which will interest our readers more than the others; though that by Dr. H. B. Anderson on "The Medical Profession" will also be of interest, since the profession is so closely associated with hospital work.

Dr. Brown opens with an allusion to the first hospital in Toronto—a church, used in the war of 1812, to receive the overflow of men wounded in a battle at Queenston. The medical officer in charge was Dr. Wm. Dunlop, who describes the event in

his little book. He now lies interred at Goderich. It would appear that this same church was used when Toronto (then York), was captured by the American forces. The British, before defeat, set fire to their powder magazine—many Americans as well as British, were badly injured in the explosion. These were attended in the hospital by the celebrated Dr. Wm. Beaumont, who was medical officer to the American forces. The particulars are related in Dr. Beaumont's autobiography.

Jumping across the years between 1814 and 1914, the history under review gives an account of the several hospitals used in Toronto during the Great War. A detailed account of their activities is given and will be read with much interest, not only by our generation, but by Canadians of the future, and will shew how Canadians—and especially Torontonians—reacted to the appeal for help to their wounded and sick soldiery.

The history of civil institutions begins immediately at the close of the war of 1812. By 1820, the York General Hospital was under construction. The site was where the Arlington Hotel now stands. It was used until 1856 and was demolished in 1862. The name was changed to the Toronto General Hospital and a new building was erected on Gerrard Street East, near the Don. In 1913 the patients were removed to the new "General" on College Street. A resumé of the work of the trustee boards and administrators is briefly given.

St. Michael's Hospital next comes under review and special tribute paid to the work of the late

Robert J. Dwyer, the first medical superintendent. Following is a description of the buildings, equipment of the Hospital for Sick Children—a monument to the late John Ross Robertson—"the most princely benefactor to the public," states Sir Edmund Osler, "that is chronicled in the history of Canada."

The story of Grace Hospital follows—the establishment with which Drs. John Ferguson, George Carveth, Price-Brown, and Hon. Thomas Crawford had so much to do.

The Toronto Orthopedic Hospital's history is coupled with the name of that first of Toronto's orthopedists, Dr. B. E. MacKenzie. Dr. John Potts, the eloquent Methodist divine, was the first president of the board of trustees.

The Hospital for Incurables began to function in 1874. Sir Mortimer Clark and Mr. Ambrose Kent are names best known, perhaps, in connection with the outstanding work of this splendid institution.

A brief description is given, too, of the old Queen Street Hospital for Insane, designed by J. G. Howard, who gave the magnificent park bearing his name to the City of Toronto.

The Wellesley Hospital established by one of our editors, Dr. Herbert Bruce; the Women's Hospital on Rusholme Road; the St. John's Hospital (Anglican); the Cottage Hospital (Miss Lash's); the Riverdale Isolation Hospital, under the control of the Medical Health Department with Miss Kate

Matheson, superintendent, all come in for short mention.

When it is known that "Robertson's Landmarks" are now almost unobtainable—a year or more ago sets were worth \$75.00—it will be seen how timely this History of Toronto is; and all buyers of it will have in their possession a work chock-full of information and one that will doubtless increase in money value more and more as time goes on.

For the Children

Here is a happy way of entertaining children who are waiting their turn in Health Clinics. This has been put in practice by that splendid old institution, the Boston Dispensary.

For Children's Day—usually Saturday forenoon, at the Clinic—an automatic lantern is set up and attractive health pictures interspersed with health allegories or legends are shown. Another attractive feature is the health railway, the road to Wellville. A little car running about on a toy railway has for its stations places like Bathtown, Earlyrise, Freshair, Fruitland or Milktown, each of which has an environment, or an equipment befitting its name. As the little train stops at the different stations, the attendant, in terms to be understood by children, impresses some essential health fact on her little hearers. That they are interested is most evident, for they remain before the miniature landscape until their names are called for examination, and even then on the way to the desk can not fail to stop a moment before the pretty stereopticon pictures of the Boston association.

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Editors:

ALEXANDER MacKAY, M.D., Inspector of Hospitals, Province of Ontario.

JOHN N. E. BROWN, M.B. (Tor.), Ex-Sec'y American and Canadian Hospital Associations, Former Supt. Toronto General and Detroit General Hospitals.

M. T. MacEACHERN, M.D., Director-General, Victorian Order of Nurses, Ottawa. W. A. YOUNG, M.D., L.R.C.P. (London, Eng.), Toronto, Ont., Consultant, Toronto Hospital for Incurables.

MAUDE A. PERRY, B.S., Supervising Dietitian, Montreal General Hospital

Associate Editors:

Ontario

C. J. C. O. HASTINGS, M.D., Medical Health Officer, City of Toronto.

N. A. POWELL, M.D., C.M., late Senior Assistant Surgeon-in-charge, Shields Emergency Hospital, Toronto.

P. H. BRYCE, M.D., late Medical Officer, Federal Dept. of Immigration, Ottawa.

HERBERT A. BRUCE, M.D., F.R.C.S., Founder of Wellesley Hospital, Toronto.

J. H. HOLBROOK, M.B., Physician-in-Chief, Mountain Sanatorium, Hamilton.

C. K. CLARKE, M.D., LL.D., Medical Director of the Canadian National Committee for Mental Hygiene, Toronto.

HELEN MacMURCHY, B.A., M.D., Late Asst. Inspector of Hospitals, Ontario, Toronto.

Quebec

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A. K. HAYWOOD, M.D., Superintendent, Montreal General Hospital, Montreal.

J. R. BYERS, M.D., Superintendent, Laurentian Sanitarium, Ste. Agathe des Monts.

Nova Scotia

W. H. HATTIE, Provincial Health Officer, Department of Public Health, Nova Scotia, Halifax.

Manitoba

DAVID A. STEWART, M.D., Medical Superintendent, Manitoba Sanatorium for Consumption, Ninette.

Alberta

T. H. WHITELAW, B.A., M.B., University of Toronto, Medical Officer of Health, Edmonton.

A. FISHER, M.D., Superintendent, Calgary General Hospital, Calgary.

Saskatchewan

J. G. WRIGHT, M.D., C.M., Regina.

M. R. BOW, M.D., Superintendent, Regina General Hospital, Regina.

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G. MURRAY FLOCK, M.B., Physician-in-charge, Essex County Sanatorium, Union-on-the-Lake, Kingsville.

C. M. HINCKS, B.A., M.B., Assistant Medical Director of the Canadian National Committee for Mental Hygiene, Toronto.

British Columbia

ARTHUR G. PRICE, M.D., Medical Health Officer, City of Victoria, Victoria.

M. T. MacEACHERN, M.D., Superintendent, Vancouver General Hospital, Vancouver.

H. C. WRINCH, M.D., Superintendent Hazelton Hospital, Hazelton.

Great Britain

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DONALD J. MACKINTOSH, M.D., M.V.O., Medical Superintendent, Western Infirmary, Glasgow, Scotland.

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DR. FRANK CLARE ENGLISH, General Secretary, Protestant Hospital Association, St. Luke's Hospital, Cleveland, Ohio.

THOMAS BEATH, M.D. (late Superintendent, Victoria Hospital, Winnipeg), Raleigh, N.C.

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Selected Articles



HOSPITAL FINANCE: A SUGGESTED SCHEME

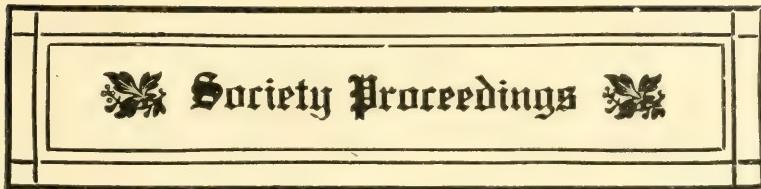
Hospital finance, especially since the war greatly inflated administrative costs has been an anxious problem for the managers of these great philanthropic institutions. There are those who say that the only remedy is to be found in State control with its deadening influence on human sympathy. If such a development were to come to pass it would be a great calamity. The maintenance of the voluntary system is worth striving for, and if the public rally in its support it can yet be saved. Useful suggestions to this end were made in a paper by Sir Napier Burnett, read at the annual conference of the British Hospitals' Association at Sheffield. Their object is to systematize and intensify the methods under which voluntary contributions are made. The British Red Cross sent out a questionnaire to over a hundred large hospitals throughout the country in regard to the working of contributory schemes, and from an analysis of the answers returned several points emerge that deserve closer consideration than they have yet received. It is found that in some cases such schemes have been in existence for half a century, so that, as Sir Napier Burnett says, if payments by patients or potential patients are inimical to the voluntary system, a destructive process has been in progress for a long time—without doing any perceptible harm, but, on the contrary, achieving manifest good. In the majority of cases the voluntary levy is deducted from the employees' wages by the firm before the wages are paid over, and this is the most satisfactory method. Where the assistance of the employer is given in this way the total sum raised is almost invariably in excess of that produced by any other means. There are figures to show that it has been instrumental in increasing three-fold the amount raised at works and organizations previously dependent upon the good offices of some voluntary collector. It

is beneficial also for the hospitals to stimulate rivalry between districts by announcing the amounts received from each, and to keep a reckoning of the number of contributors each year as well as of the number treated. In the majority of English hospitals payments are now asked for from patients who are not members of a contributory scheme. Inducements to join such a scheme are that by so doing a less fortunate comrade may be helped when in need of treatment, that the contributor and his family may get treatment should it be required, and that a contributor shares in the management of the hospitals. It is remarked that particular emphasis should be laid on the first-mentioned of these considerations if the voluntary system is to be fostered. There is widespread evidence of the desire to keep "the voluntary gift to help another" as the main idea in a contributory effort. The hospitals, on their part, should clearly state the liability they undertake. Contributors should be informed that the conditions on which they will be admitted are that they are suffering from complaints suitable for hospital treatment, and that there is room for them in the hospital. The contributory class is generally limited to those whose income is below a certain figure, and this also is found to be advisable.

While public hospital treatment is intended primarily for the working classes, the so-called "middle-class" patient of moderate means deserves special consideration. In many cases such patients are ineligible for admission because of rules laid down, it may be, in the charter of the institution, such as "for the sick and lame poor." On the other hand, their income is frequently insufficient to enable them to go into a private hospital or nursing home. An increasing number of those who before the war were in a position to pay for private treatment now apply, the Vice-Chancellor of London University said yesterday, to the voluntary hospitals. It is a serious financial crisis for patients of that description to be overtaken by illness that may involve long absence from work with cessation of income, residence in a private institution, and possibly in addition the costs of operative treatment. Not only that, but the large hospital generally possesses equipment and facilities that are not fully available elsewhere. Such patients, therefore, may suffer real hardship in being unable to participate in the benefits of modern hospital sci-

tific resources. In some hospitals a small number of beds have been set apart for paying patients, and that these are regularly occupied shows that they are fulfilling a felt want. In American hospitals the accommodation given to patients is graded in accordance with the rates they pay, but that system has not been followed in the public hospitals of this country. Patients admitted to the reserved beds are charged from two to five guineas a week towards the cost of maintenance, and in some hospitals they also pay for treatment. The most novel suggestion in the address was designed to cover the middle-class patient with an income between £250 and £600 or £700 a year. Sir Napier Burnett proposes a scheme of voluntary insurance. He calculates from the sickness incidence, which is considerably less among the middle than among the working class, that a premium of £2 per annum, with the option of paying quarterly or half-yearly, would suffice to cover costs and to leave a margin over for the hospital "pool." The medical staff, he says, could not reasonably be expected to render voluntary service to such patients, and an agreed percentage of the "pool" would, therefore, be paid into a medical staff fund. It may be asked whether hospitals could at present supply the requisite accommodation. Sir Napier Burnett thinks they could, because a number of patients make use of their services without payment, although they are in a position to pay some part at least of the costs. With regard to the necessary machinery to run the scheme, it is suggested that it could be provided on the lines of the existing contributory scheme organization. To call in the services of the recognized insurance companies would mean remunerating them, and thus diminishing the benefits that would accrue to the hospitals. Indeed, the most important aspect of the scheme is that it would open up a fresh avenue of finance for the voluntary hospitals and enable payment to be provided for their medical staffs. Conditions vary in different localities, and no hard and fast methods can or should be laid down, but Sir Napier Burnett's suggestions may prove useful where a reorganization of hospital finances is urgent.

—*The Scotsman*



Society Proceedings

THE ALBERTA HOSPITALS ASSOCIATION

CHARLOTTE E. MELROSE.

The annual meeting of Alberta Hospitals Association opened in Calgary, Thursday, Sept. 5th, with representatives from Calgary, Holy Cross, and General Hospitals; McLeod; Lethbridge; High River; Drumheller; Medicine Hat; Red Deer; Edmonton Misericordia, General, and Royal Alexandra Hospitals.

The treasurer showed a favorable balance. The committees were appointed and the following gentlemen were asked to act upon the Special Legislation Committee: Dr. H. R. Smith, Dr. A. E. Archer, W. T. Henry, Esq., and E. E. Button, Esq.

In the afternoon, Dr. Crawford, in the absence of His Worship Mayor Webster, extended greetings on behalf of the City of Calgary and spoke upon the difficulty of financing hospitals.

Mr. Christie, of The Ontario Laundry, gave a splendid talk upon laundries and said it was his opinion that the great leakage in hospital laundries was due to the lack of co-operation between the nursing staff and the laundry staff.

Mrs. de Stage, of the Holy Cross Hospital, gave a detailed account of the Record System as used in the Holy Cross Hospital, and shewed how easily a threefold record of each case admitted to the hospital might be kept, viz: (a) the patient's personal record; (b) a record of the disease itself; (c) a record of a doctor's patients. This paper brought forth a great deal of discussion, and dissatisfaction was expressed with the system adopted by the government in obtaining records from hospitals, and the Deputy-Minister, who was present, promised to take up the matter.

Mr. Norman McLean spoke on the problems and achievements of the Municipal Hospital, and this evoked a great deal of discussion.

Friday morning a most instructive paper prepared by Mr. A. W. Edwards, manager of the Palliser Hotel, was read by the secretary. Mr. Edwards spoke of the psychological effect of subdued tints on the inmates of a room and suggested pictures in wards and rooms, especially in children's wards.

Dr. Washburn, of Edmonton, gave his personal impressions of hospital management as seen on his recent trip to Eastern Canada and the United States. He had visited the Toronto General. Here the lack of interest in a visitor struck him unfavorably. In the Massachusetts General he was impressed with the clock-work precision of supplying information about the patient to the patient's friends. This was favorably commented upon, but Dr. Washburn spoke of the Ross Pavilion in connection with the Royal Victoria Hospital, Montreal, as the *ne plus ultra* of hospital work and management that he had seen. The way the food was served was especially commented upon. This was a point that appealed to me when I visited the Royal Victoria Hospital in October, 1922, and of which I spoke to the Royal Alexandra Hospital dietitian upon my return.

The election of officers for 1923-4 now took place with the following results:

Honorary President, Hon. R. G. Reid; President, Dr. H. R. Smith, Edmonton; Vice-President, E. E. Dutton, Esq., Lethbridge; Secretary-Treasurer, S. V. Davis, Edmonton.

The Executive Committee: Father Cameron, Calgary; Dr. Washburn, Edmonton, E. W. Starkey, Esq., McLeod; H. B. Stickney, Esq., Morrin.

The four resolutions forwarded by the Edmonton Hospital Board *re*: (a) Home for aged persons and incurables; (b) Government help for hospital training schools; (c) Government grants towards free treatment of children suffering from bone disease or deformities; (d) Change in existing legislation with regard to collection of accounts, were endorsed by the Provincial Meeting and turned over to the Special Legislation Committee who were instructed to bring these and others to the attention of the Provincial Government at the earliest opportune time.

Friday noon the delegates were entertained at luncheon at Bowness Sanitarium and after luncheon a visit was paid to the various units and a very interesting symposium was given by

Dr. L. S. MacKid, Calgary, and Dr. A. H. Baker, Superintendent of Sanitarium.

Dr. Archer spoke on: What we like best and require most from the doctor (the hospital's viewpoint). Care and attention in keeping of records was stressed.

Dr. Lincoln spoke on: What we like best and require most from the hospital (a doctor's viewpoint). He stressed co-operation and a faithful carrying out of orders.

In the evening a public meeting was held in the Al Azhar Temple, which was poorly attended.

Dr. Dunlop gave a careful resumé of the advance of medical science and Dr. Collisson, of Red Deer, spoke of a doctor's usefulness as a physician and as a citizen in a community, speaking from a long experience in a rural district.

The Chairman, The Hospital Board, City.

DEAR SIR: A previous engagement prevents my attending this meeting, wherefore I am submitting for your consideration the impressions brought away from the hospital session of the Medical Conference, recently held here.

I was deeply interested by the address of the Rev. Father Moulinier. The position he has attained in the hospital world, and his presence as a lecturer in such company, established that he was qualified to speak and advise on the subject matter of his address. And as he viewed the position from the outside of the medical ranks, his conclusions had a special value. Throughout his address he emphasized the necessity, that the records of each case be faithfully; and in an instructive manner, filled up by the doctor in charge of the case. He claimed that the patient and the hospital were entitled to the possession of an instructive record of the details of the case, including the medical and social condition of the patient at the time the said patient left the hospital. The patient was entitled to have these records filed with the hospital so that in the event of future treatment the ground which had already been gone over would be at the service of the practitioner attending the patient. Failing the existence of such a record all the knowledge of the patient's condition acquired during previous treatment is lost, and the next doctor would have to start in the dark, and find out what he could of the case.

The patient's loss under such conditions is obvious. For reasons bearing upon the history of the case recorded, and also

to provide guidance for treatment in similar complaints, the hospital has its own title to be in possession of the records of each case treated within its walls. Having stated these reasons, the claim of the medical profession that such records be kept, and be provided is very clear.

From this subject the reverend gentleman passed on to the question of the staff conferences at our hospitals. Once again the necessity for the regular and conscientious carrying on of staff conferences was advanced as the just claim of the patient, the institution, and the whole medical profession.

While I am only crudely outlining these matters, they were advanced with eloquence, and exact and business-like reasoning. The lecturer claimed that the standardization of hospitals was based upon these two essentials and could not survive unless they were conscientiously and unremittingly carried out. He was quite uncompromising in his statement that the standard value of the hospitals hung upon the development arising from these two activities.

Having heard this lecturer my mind went back to the able address given by our superintendent, Dr. Smith, who detailed the exhaustive provisions made in our institution for the very records referred to. No one listening to Dr. Smith could imagine that any recording facility had been unprovided for. It only remained for the doctors in charge of the case to do their share by filling in the history of the case.

This history, we had just been told, was the service to which the patient, the hospital and the profession was entitled to; and in consideration of the obtaining of which, the hospital is given the standard rating.

The utterances of the lecturers of this conference may be taken at their face value, at least this is the impression that a layman would gather. If this is so, it is part of our duty to endeavor to assist the superintendent to give effect to their recommendation.

I understand that it was at the wish of the hospital board that the Royal Alexandra received the standard rating. If this is so the board is vitally concerned that the hospital neither loses its rating, nor deserves to do so; and it would be well to discuss with the superintendent whether he was obtaining sufficiently satisfactory records or not: and if not, to see in what way the board as a body responsible for the conduct of

the institution, could assist him to fulfil his needs in the matter.

It is evidently impossible for every medical man to attend the staff conferences at every hospital in the city; but a plan might perhaps be devised whereby the doctors who principally use the hospital, be constituted the staff doctors for the time being. By this means each hospital would have the benefit in its staff conferences of those doctors associated most closely with the institution. The same benefit would obtain to the doctors concerned. Again this is a matter in which to obtain the guidance of the superintendent. The writer has not discussed the matter with him and is only voicing impressions which he carried from the hospital session of the conference.

The other two matters which I found most interesting were the lectures on the X-ray Department and the Laboratory.

Each of the able lecturers made the following statement:

"While the financial aspect of the department in review does not come within the scope of my paper, there are several methods by which this department can be made self-supporting. This, while providing the best service for the patient, which is, of course, the reason for the existence of the department."

No doubt these gentlemen knew what they were talking about, and their assurance should be the grounds of conference between the superintendent and the board, or in any case the financial branch of the board.

Yours very truly,

GEO. BEART.

Edmonton, Alberta

Canadian Hospitals

THE HOSPITAL FOR INCURABLE CHILDREN

A work of faith that goes on with a solid, consistent growth year by year is that carried on at the Hospital for Incurable Children, Bloor Street East, Toronto. At the annual meeting, held on November 2nd, reports were presented revealing the extent of the year's developments, and, again and again, reflecting a spirit of deep thankfulness for the success achieved.

H. H. Cameron, K.C., presided, and after the opening prayer by Rev. Stuart Parker, drew attention to the splendid results accomplished in the past twelve months.

The health of the children had been remarkably good, said Dr. J. C. Maynard, reporting for the medical staff. There was no infectious disease, though several patients were given special orthopedic and surgical treatment in other hospitals and returned to their "home" as soon as possible. The mental tone of the patients had shown great improvement, following the decision not to admit feeble-minded children.

It was with sincere and profound regret that the death during the year of Dr. Bruce Robertson, who had been closely interested in the work, was recorded. His place on the Board of Specialists had been filled by Dr. A. B. LeMesurier.

The Treasurer's report, read by Miss W. Freeland, showed total receipts for the year ending September 30 of \$32,029, which included general donations of more than \$3,000 and legacies of \$6,987; total maintenance cost of \$20,123, and a balance in hand of \$2,551. Regular receipts showed a decrease of slightly over \$1,500 from the amount received during the previous period, while total maintenance cost was nearly \$200 less than in 1921-22.

Mrs. G. Tower Fergusson, in the absence of Mrs. R. A. Donald, presented the report of the Honorary Secretary. Referring to the proposal to delete the word "incurable" from the name of the home, because of the so-called depressing effect on the children, parents and passers-by, the report pointed out that so far as the children were concerned there was no objection whatsoever; rather they were glad of the good fortune

which permitted them to enjoy the comfort and happiness of such a home.

Major-General J. T. Fotheringham, in a most interesting address, traced the science of child welfare from its earliest beginnings. Other speakers were: Mrs. John I. Davidson, R. A. Donald, G. Tower Fergusson and Philip Jackson.

PRESENTS MEMORIAL TO INFANTS' HOME AT ANNUAL MEETING

The presenting of a memorial tablet to the Infants' Home, Toronto, was an important feature of the annual meeting held recently. The tablet, which is made of walnut, bears the names of the Board of Managers, 1875-77, those of the founders of the home, of the first patrons, and of the presidents (including that of Mrs. J. D. Tyrrell, who since 1919 has guided its fortunes). The names also of the endowed cots and rooms are given, all being outlined in gold letters. The ceremony of unveiling which usually accompanies such a presentation was omitted, but Sir William Mulock, on behalf of the present board, delivered the speech which formally made the tablet the possession of the institution, speaking with warmth and sincerity of the splendid efforts of the pioneers of the home, and with appreciation of the efficient service of the officers of to-day.

The annual reports were of an optimistic character, the only depressing announcement—that of a deficit of over \$2,000, including bills payable—being followed by the heartening news that a friend had cleared the home of all indebtedness. The total receipts of \$54,324.50 included \$14,114 from relatives of the children cared for; \$26,621 from the Federation of Community Service; \$6,326 from the City of Toronto, and \$3,596 from the Province of Ontario.

In presenting the Treasurer's report, C. F. Jackes emphasized the fact that the Infants' Home does not receive the proportion of bequests that is its due, and suggested that the attention of charitably disposed persons should be directed toward it in order that it may share in their remembrances. The amount garnered in by the boxes placed in banks and other places of business amounted to \$2,242.48, the salvage sale produced an income of \$460.63, and the Cent-a-mile Fund brought

returns which admitted of the installing of the handsome tablet and left a substantial balance.

In her report on Home Finding, Mrs. A. D. Fisher told of the increasing satisfaction year by year of the present system of finding homes for the babies. The children, she said, are no longer denied a normal life, but are enabled to develop as individuals and not as machines. Another benefit of the system is that in many cases bereaved parents find solace in the care of the friendless infants.

Dr. A. P. Hart and Dr. F. S. Park of the medical staff of the Home spoke with enthusiasm of the work from a health standpoint. Dr. Hart recommended the weekly clinics, of which 47 had been held during the year for babies under one year, the average attendance being 30. For children over one year, 48 clinics had been conducted, 17 being the average attendance. Out of 458 admissions there had been fifteen deaths, a slightly higher percentage than last year, but accounted for by conditions beyond a doctor's control. Dr. Park spoke of the effect of the foster home on the health of children, declaring the element of love found there to be the secret of an attractiveness and wholesomeness not apparent in children reared in an institution. He paid a tribute to the foster mother, who, in most cases, proved to be a woman of heart and wisdom. Mrs. J. K. McMaster reported 526 applications to the home, with 204 admissions and 322 cases otherwise assisted. The children adopted for the year numbered 59.

GRANTS OF \$125,000 FROM BOTH CITY AND PROVINCE PLEDGED TO HELP IN EXTENDING WORK TO AID INCURABLES

The Toronto Hospital for Incurables held its forty-ninth annual meeting on October 26th, at which Hon. Lincoln Goldie, provincial secretary, informed the Board of Management that the Province would give \$125,000 to the Incurables' Hospital for the continuance of the carrying on of this important work.

The president of the board, Ambrose Kent, said in his address that the city had also been asked for the same sum, and the answer was: It would be forthcoming if the Province set the example; so that now, with the board taking the responsi-

bility for raising \$50,000, the hospital has \$300,000 with which to maintain, develop and enlarge, the institution, which, with its present accommodation, is unable to cope with the demands of all that claim admittance.

The need really calls for a building twice the present size, and the northwest corner of the lot affords ample room for another structure, and work on the foundation of this may begin before the spring. With its present capacity, twelve have to room out, and forty-six applicants for admission could not be received.

The superintendent, Miss E. M. Cook, in her report for the year 1922-23, said there were 227 patients in the hospital on September 30; 299 were cared for throughout the year; 5 discharged, 67 deaths, and 67 admissions. Although many of the patients were utterly helpless, one man having never stood on his feet for nineteen years, and ultimately losing his eyesight, Miss Cook said that, despite great handicaps, they had a little workshop in the basement, where toys, lamps and other articles were made by the inmates. Also, in the wards where patients were perpetually confined, ten large electric fans were installed by the proceeds from their bazaar.

Miss I. Z. Groat, secretary-treasurer, stated in her report that the expenditure for the last year was \$177,143.66, and their receipts totalled \$168,871.48.

In commemoration of the president, Mr. Kent's twenty-five years of faithful and unceasing efforts in behalf of the incurables, the board presented the institution with a large portrait of him, which was unveiled by Miss Mortimer Clark.

The present Board of Management remains in office, as follows: Mrs. Grant Macdonald, Miss Mortimer Clark, Mrs. J. P. Balfour, Mrs. A. Cowan, Mrs. William Davidson, Mrs. S. F. Fountain, Lady Hearst, Mrs. Stewart Houston, Mrs. Ambrose Kent, Miss Grant Macdonald, Miss Effie Michie, Mrs. Hugh MacMath, Miss J. M. McGee, Mrs. William Sparks, Ambrose Kent, Noel Marshall, John Macdonald, Dr. W. H. B. Aikins, W. A. Baird, Rev. W. E. Baker, Rev. Canon Bryan, George W. Booth, John Firstbrook, S. B. Gundy, Ven. Archdeacon Ingles, W. G. Kent, Dr. Edmund E. King, E. J. Lennox, R. Millichamp, Mayor Maguire, J. O. McCarthy.

CHRISTIE STREET HOSPITAL

The comprehensive scheme that directs D.S.C.R. activities at Christie Street Hospital tends to make this institution complete within itself. From butcher shop, to boiler room, to movie palace, are but steps in the synthetic plan that makes the hospital more than a mere institution. It is a community practically depending on its own resources, in so far as the daily round of life is concerned. Federal authorities have seen to it that money should not be spared in an effort to strengthen the sense of unity and completion that prevails at Christie Street.

Soldiers with service disabilities need merely follow the customary channel of admittance and they will be welcomed. Such a procedure is a simple and effective one. The soldier comes to the hospital and asks for a doctor. He is directed to the particular clinic that will consider his ailment. There the doctor examines him and, if necessary, refers him for a special examination. The doctor may see fit to advise the applicant to report at regular intervals to the clinic for it may be possible that his case requires but casual treatment. These clinics are equivalent to the outdoor clinics at the General Hospital. They include all branches of medical science and are open from 9 a.m. to 5 p.m.

But if an ex-soldier suffering from an army disability is unable to come to the hospital, even though it be five years after his discharge, a D.S.C.R. officer goes to his home and attends to him in the manner of a private physician. At all hours a medical officer is available for this work. Those patients who are receiving casual treatment at the hospital have their prescriptions filled in the adjoining dispensaries before they leave the building. The patient receiving home treatment has his medicine brought to him by the doctor or by a social service nurse.

Dr. Hewitt, of the administration staff explains that many ex-soldiers sought assistance on the ground of patriotic sentiment or distinction in service, whereas matters would have been considerably facilitated if the claim had been based purely on an army disability.

Once within the hospital the soldiers become one of that unique and gallant little community some 400 strong. A staff of fifty graduate nurses are administering to the wants of the

men. Ten resident physicians and a large staff of consultants are in attendance.

Like most communities, this one at Christie Street has its gradation. It is only just to consider first the spinal ward on the fifth floor. There are thirty-four surgical tubercular cases. Some of these men are not only prostrate, but require the use of the Bradford frame, adjustable according to the required position of the body. And yet the spirit of the men is admirable. Some of them indeed are able to sit up and they have a quiet confidence in their ultimate recovery. One is surprised at the nicety with which they employ their reflecting mirrors. Almost as soon as one enters the door his image is visible to the men, and there are a number of them who are continually drawing or writing while remaining on their backs.

The successful treatment of these cases depends largely upon their exposure to sunlight and air. Thus they are adjacent to the roof, where they can be readily wheeled. Sometimes sunlight is not available. Then they depend upon large Alpine lamps which generate artificial sunlight. There is very little surgical work in the treatment of these cases. These men are far from being despondent. They realize that sixty of their comrades have been discharged as cured. In any event every provision possible under the circumstances is offered for their entertainment. A handsome radio outfit is a great favorite with the men.

On the fourth floor are the nose, throat and eye clinics, and the much discussed diabetic laboratory. There is one case in particular that bears mention. This man, who is in a room by himself, came to the hospital troubled with pulmonary lesions and diabetes. As he put it himself, he "came there to die." Thanks to the use of insulin, he gained forty-five pounds, and is able to sit up, enjoy food, and chat amiably with visitors. He is a most active person. The radio set, the result of his labor, is a marvel of neatness and accuracy. Radio is his hobby. He declares that he feels sure that he heard Lloyd George's speech by radio more clearly than the more fortunate ones who had been able to go to Massey Hall. On this floor there is nothing quite so astounding as his progress. It is interesting to watch the nice manipulation of the X-ray apparatus in its depart-

ment. Then, too, there is a sitting room and piano easily accessible to the patients of this floor.

General medicine occupies the third floor. In addition to the chest clinic, the amputation cases awaiting the shrinking of stumps are on this floor. In one ward there are sixty-five beds. There is very little of the staid formality one associates with a hospital noticeable in the ward. In the centre is a small space made into a sort of lounging room. A gramophone is there and the inevitable radio set. Then there is the usual floor sitting-room available to visitors and those patients who are able to get around. Some one is usually at the piano, and the strains of music, not only on this floor, but on the others as well, help to give that very distinctive touch to Christie Street Hospital.

The hospital library is on the second floor. It is a commodious and well-stocked room, and seemed to possess a bewildering amount of literature when one considered its size. The Y.M.C.A. employs a man to look after the library, and at the same time he relieves the hospital authorities of the difficult task of looking after the various forms of recreation. The general surgical ward on this floor has a great variety of interesting cases, for the most part men whose lives have been actually saved by the prompt and effective treatment of the house physicians. It is not stretching the truth to say that a great number of these men had abandoned all hope when they offered themselves for treatment. Some of them are very eager to tell of their truly amazing progress. Incidentally Dr. McMane, the hospital superintendent, said that it was remarkable how willing some of the boys were to give a small piece of bone or their blood to less fortunate fellows.

A commodious space is given to the quarters of the Euclid Hall boys on the first floor. They have two rooms, one the actual ward, where a great effort has been made to eliminate the hospital atmosphere, and the lounging room, distinct in every way from anything of that sort one would expect to find in a hospital. There are billiard tables, where true dexterity may be observed when the men spin in their wheel chairs from one corner of the table to a finer point of vantage to execute some difficult shot. These men are billiard

players of no mean order, and very often defeat their visitors. Of course, radio is there. Two sets, in fact.

In the basement is where one realizes the broad scope of this institution. In the engine room 580 horse-power is generated; four tons of coal are required to heat the place on a cold day. And here they have their own steam pressure cookers, their own butcher shop, their own grocery store, and it might be well to say they have their own dietetic staff. There is a cloakroom such as one would find in any modern hotel, where the patients check their wraps. The barber shop lacks nothing but a barber pole. The canteen sees to it that the incidental wants of the men are supplied. Then there is the dining hall capable of seating nine hundred.

Quite the most interesting features of a rather unique hospital are the departments devoted to leather and basket work. Fortunately the men are able to work according to inspiration, rather than systematically. In this way there is a great variety to the work. Telephone pads, music rolls and a great assortment of oddities in leather testify to the skill of the men. In the basket work department they weave with a skill and patience which would be a credit to the actual craft. It should be understood, however, that this work is purely therapeutic, the idea being to increase the fluency of the fingers and loosen up the joints, stiff after long inactivity. The authorities do not concern themselves with the actual money value of the work.

From the basement there is a long runway that leads to the auditorium, which is the entertainment centre. It is at times a movie palace, a theatre, and a concert and assembly hall. Every Sunday afternoon during the summer months the Toronto Musical Protective Association provided a band, and during the winter months some of the finest of the city orchestras play there.

A well-equipped gymnasium completes an extraordinary building.

The grounds of the building are not large, but they serve the requirements of the patients. There is a baseball field, tennis courts in the summer, and a rink during the winter. Certainly among the most distinctive features of the grounds are the nurses' residence and the red cross lodge. Expense has not been spared to give the nursing sisters pleasant little

comforts that make the residence homelike and agreeable. The red cross lodge is a haven for the patients who seek a change of atmosphere and a pleasant place to receive their friends. Its furnishings are rich and even luxurious, and in many ways its lounging room surpasses any room connected with the hospital.

RECEPTION HOSPITAL IN TORONTO BECOMES ACTUALITY

In the presence of a little group of physicians and psychiatrists—men who have worked hard to establish in Toronto adequate provision for the care and treatment of incipient mental diseases—the corner-stone of the new Reception Hospital on Surrey Place was well and truly laid by Mayor Maguire on October 12th.

There was less ceremony than usually marks these formal services. Scarcely fifty persons were present; but a feeling of something accomplished pervaded the simple service; an up-to-date institution, long needed in Ontario, was well on the way to become an established fact.

Dr. C. K. Clarke, former Dean of the Faculty of Medicine, University of Toronto, voiced feelings of gratitude that this needed want was at last to be filled. Hon. Dr. Pyne recalled Dr. Clarke's long labor to have a reception hospital established here; for twenty-five years Dr. Clarke has worked with this end in view, he said.

In the erection of the hospital, city, Province and University have co-operated. The University of Toronto provided the site, the city the building, and the Province will administer the institution. At the ceremony all these bodies were represented.

From the University there were present Sir Robert Falconer, Dean Primrose of the Faculty of Medicine, Dr. C. K. Clarke, and other leading physicians and psychiatrists. Hon. Lincoln Goldie, Provincial Secretary; Dr. Harvey Clare, Provincial Psychiatrist; and W. W. Dunlop, Inspector of Hospitals and Charities, represented the Province. There was a large civic delegation, including Mayor Maguire, Controller Hiltz, City Architect Price, Commissioner Daniel Chisholm, Dr. C. J. O. Hastings, Chairman Hacker, of the Property Committee, and Ald. Dr. Risk, Donald C. MacGregor, R. H.

Cameron and Magistrate Jones. Among others present were: Dr. W. M. English of Hamilton, Dr. Stowe Gullen and Mrs. Huestis of the Toronto Mental Hygiene Committee. Rev. Dr. E. A. Henry of Deer Park Presbyterian Church offered the invocation.

Sealed in a copper receptacle, in the centre of the stone were placed reports of Lloyd George's reception and speeches, all the Toronto newspapers of the day before, the coins of the realm and a record of the steps leading up to the erection of the institution.

WOODSTOCK HOSPITAL TRUST

The Board of Trustees elected at the annual meeting of the Woodstock Hospital Trust are: John A. Bain, Dr. A. M. Clark, E. J. Coles, T. L. Hay, E. W. Nesbit, James Dunlop, John R. Shaw, W. J. Taylor, John D. Patterson and H. A. Little. Mayor Murray and Warden Hollier become members of the Trust by virtue of the offices they hold in the city and country. Harry Sykes and George Otten were reappointed as auditors.

HOSPITAL MATRON RESIGNS

Miss Failes has resigned her position as matron of Hanover Memorial Hospital, owing to ill-health. The new superintendent is Miss Reynolds of Stayner, Ont., who comes to Hanover from Winchester, Va., where she has been engaged in hospital work. Miss Reynolds was formerly matron of Goderich Hospital.

FELLOWSHIP FOR INTERNS

Toledo, Ohio, Hospital, of which P. W. Behrens is superintendent, recently announced the foundation of a fellowship for interns. The award will be \$1,000 and will be given to the intern doing the best scientific work and writing the best thesis, as decided by the executive committee of the staff.

Book Reviews

Practical Dietetics with reference to diet in health and diseases, by Alida Frances Pattee, Graduate, Department of Household Arts, State Normal School, Framingham, Mass.; former Instructor in Dietetics, Bellevue Training School for Nurses, Bellevue Hospital, New York City. Fourteenth edition, completely revised. A. F. Pattee, Publisher, Mount Vernon, New York. 1923.

It is but seldom that any book, whether for nurses, doctors or the general public, has to be revised almost every year. It must be a source of gratification to any author to be called upon to do so. Such is the case with Miss Pattee's "Practical Dietetics," resulting in its fourteenth edition being revised throughout. Any book that has become "better and better" is quite safe to purchase and read "every day in every way."

Hughes' Practice of Medicine. Including a section on mental diseases and one on diseases of the skin. 12th edition. By R. J. E. Scott, M.A., B.C.L., M.D. With 63 illustrations. Philadelphia: P. Blakiston's Sons & Co.

This handy volume of 800 odd pages covers in a succinct and fairly thorough way the field of medicine for students, nurses and young practitioners. The various diseases are grouped in classes, and are discussed systematically under certain causation, pathology, symptoms, signs, prognosis and treatment. Each new edition includes a description of the newer diseases and any new phases of the older ones. New sections deal with trench fever, acidosis, kidney function, heart irregularities and the like. One notes the various formula with approval; for after all the ultimate end is to relieve the patient. After the wave of therapeutic nihilism which rightly laid stress on diagnosis and laboratory and pathologic studies, we welcome any work which stresses treatment; and the tyro is always pleased to have available some of the standard formula to which he may refer when giving prescriptions. The chapter on physical diagnosis will also be valued.

SIGNAL SYSTEMS FOR HOSPITALS*

Recent years have brought about many discoveries in the medical and electrical branches of science. Electricity and electrically operated appliances are continually being used by the medical profession, and the demand for reliable electrical equipment is becoming acute. Hospital Signal Systems are a small but important part of the electrical field used by the medical world, and it doubtlessly would be of great advantage to doctors and those connected with the management of hospitals to investigate the merits of the various systems. Realizing the importance of Hospital Signal equipment, manufacturers have placed on the market a number of high grade systems, some of the most important being: Silent Nurse Call Systems, Doctors' Silent Paging Systems, Fire Alarm Systems, and Interior Telephones. The value of Nurse Call, Fire Alarm and Interior Telephone Systems, need not be commented upon. However, Silent Doctors' Paging Systems and In and Out Annunciators are not so well known, though doubtlessly in the near future they will become part of every hospital. With the Doctors' Silent Paging System, a doctor or official can be quickly located throughout the hospital without any noise or confusion, by means of light signals displaying a combination of letter and figure. How many times does it not happen that a doctor, having an important private practice, upon entering a hospital becomes difficult to locate, and his private practice very often suffers. With the adoption of the Paging System, such conditions are reduced to a minimum. When hospitals are equipped with In and Out Annunciators it is possible to see at a glance whether certain parties are on the premises without inconveniencing or restricting those who use the Annunciator. This is accomplished by placing a small sending station at the various entrances connected to one or more indicators. The brief description given only leads to an insight of the numerous systems that are available. There are companies specializing in equipment of this nature, who would be only too pleased to act in a consulting capacity and lay out Signal Systems that meet all requirements; therefore, no institution should deny themselves this valuable service.

*A firm who specializes in the above equipments is The Connecticut Telephone & Electric Co., of Meriden, Connecticut, who will gladly give estimates on request.

NEW DEVELOPMENTS IN THE MICROSCOPE

The last few years have seen considerable development in the microscope, which has contributed to the convenience and utility of this necessary piece of laboratory apparatus. The idea of so constructing an instrument as to permit of the use of both eyes, in other words the binocular microscope, is by no means new. It is a fact beyond question that eye strain frequently results from the use of one eye while the other is left idle, whether closed or not, for considerable periods of time. In fact the binocular microscope has done even more than to prevent eye strain. It has served in many instances to bring back into service an eye which through long continued disuse had, partially at least, lost its keenness. Recent developments, however, have brought this convenient accessory within the reach of the ordinary laboratory worker. This has been done by so adjusting the stand as to make the binocular body and the single tube easily and quickly interchangeable. The same instrument is thus available for binocular vision when required, or for monocular work where problems of illumination are difficult, or where Camera Lucida drawing are required, or for making photo-micrographs. Improvements have also been made both in substages condensers and in mechanical means for their manipulation. The purpose of the old Abbe type of condenser has been mostly to flood the object with light, but the importance of corrected or achromatic condensers has long been recognized, attention having been given to the improvement of which not merely concentrate light on to the object, but furnish a well directed cone of light which passes through the specimen and into the objective. In order to fully utilize the advantages of high grade condensers, it is necessary that they should be accurately focused. Substages are, therefore, provided in which the condenser may be focused not only by the standard rack and pinion movement, but by a fine adjustment as well, permitting focusing of the condenser with the same accuracy that is applied to the objective itself. If a well constructed condenser is correctly focused on the specimen and then while the object is under observation is slightly displaced, a haze will be seen immediately to appear in the field. This haze always exists with uncorrected or improperly focused condensers. Of

course, the fine adjustment of the substage would have no advantage unless used with a condenser capable of accurate focusing.

It is true, furthermore, that condensers best suited for one objective are not necessarily best for other objectives of a different power. This involves the necessity of a convenient means of interchanging condensers. This has been provided in a new Spencer microscope by furnishing a fork in the substage into which different accessories may be slipped horizontally instead of forcing them in or out of a ring as in the old device. This makes changing of substage accessories practically as convenient as the changing of objectives. The substage fork is also capable of receiving either the standard substage dark field illuminator or the special illuminator with electric light included. With the introduction of this type of substage, it is expected that further experience in the use of various substage devices will demand a constantly increasing variety of such devices. A further improvement has been made in the method of handling the slide which has ordinarily been placed on the stage of the microscope. The objection to so placing it is that after oil contact has been made between the lower surface of the slide and the condenser, the stage is smeared by the oil when the slide is moved. The improvement consists of a mechanical carrier for the slide in which the slide is supported without resting on the stage of the microscope. Thus when it is moved about oil is not spread over the microscope stage.

In the construction of objectives little definite progress has been made in the last dozen or more of years. This is not because no careful attention has been given to the matter, but because objectives have become so thoroughly well developed that there seems little opportunity left for improvement. In these days of wonderful progress in many fields, it seems almost absurd to state that the limit in any direction has been reached, but until some new fundamental principle of optics is discovered we cannot look for further marked progress in objective construction. This is not true of eyepieces. It has been the customary practice to so construct eyepieces that the image which is formed by the objective is viewed through a single uncorrected lens. There have recently been introduced eyepieces in which this lens is both

chromatically and spherically corrected. Eyepieces thus constructed are made by the Spence Lens Company under the name of Planoscopic Oculars. When used with such oculars the superior qualities of a good objective are more completely utilized. Thus we find that while we have been inclined to regard the microscope as an instrument that had reached the height of its development, that this is true of objectives only. Improvements are constantly being made in the mechanical design of the instruments, in the construction of the illumination or condensing systems and in the eyepieces by which the objective images are viewed.

PUBLISHER'S DEPARTMENT

STANDARDIZED HOSPITAL CHARTS

With the advent of The R. J. Lovell Co., Ltd., into the field of hospital supplies, all hospitals and sanitoriums have a source through which they can purchase standardized charts and records from stock, in any quantity, at any time, and at exceptionally low prices. The name "Lovell" has been identified with printing and publishing for well over half a century —dating back before Confederation. Those who lived during those stirring days when Canada was in the formation learned their first lessons from Lovell's geography, and other school books published by them. For some years special attention has been given to the production of loose leaf ledgers, account books, stationery, forms for various purposes, and office supplies. These are made in Canada, in their own plant, and are conceded by enthusiastic users throughout Canada to be the most carefully designed and most satisfactory goods on the market. Among the many forms intended for hospital use, are the improved physical examination charts, clinical charts, and temperature charts. These have been prepared after consultation with many of the leading physicians and hospital authorities in Canada, Great Britain and the United States, and have been enthusiastically endorsed by prominent members of the medical profession, among whom there is a strong and growing sentiment in favor of standardized forms. It is obvious that the use of standard charts would greatly assist the physician or surgeon when going from one hospital to another, as the information on a chart would be uniformly pre-

sented and quickly comprehended. The work of nurses would likewise be greatly simplified. These forms, including those of The American College of Surgeons, are kept in stock for prompt shipment. Not only is this a great convenience to the buyer, but it also gives him the benefit of a superior article at a much lower price than has heretofore been paid. A feature worth noting is that the majority of these forms are lithographed—not printed—giving a much smoother writing surface, and avoiding the tendency to curl, so often found in printed forms containing a large number of ruled lines. Sample forms will be gladly sent to any physician, nurse or hospital official, who will advise what forms are wanted. Suggestions as to their improvement will be welcomed, as it is only by the co-operation of those using them that these forms can be brought to the high state of perfection aimed at by the manufacturers, and made most serviceable to the users. Address all inquiries or suggestions to The R. J. Lovell Company, Ltd., 144-150 Simeoe Street, Toronto. See advertisement on page xix.

CATARRHAL VACCINE RESPIRATORY, P.D. & CO.

While cold weather is considered the proper season for colds, if there is any proper season, the fact is that the microbes are not a bit particular. All that they are waiting for, at any time of the year, is a sudden change of temperature for which the individual finds himself unprepared, or some digestive difficulty that impedes the circulation of the blood, or as some authorities declare, contact with a "sneezer." Certainly "colds" are not confined to the winter season. Somebody or other has a cold every day in the year. Some of your patients are peculiarly subject to respiratory disorders. Why not immunize them? It has been done thousands of times with the P.D. & Co.'s Catarrhal Vaccine Respiratory. Four to six injections will usually suffice; your patient is then protected for several months; not permanently, perhaps, until he has had four or five courses. The Vaccine is used also in treatment with good effect. All the Parke-Davis vaccines are of high quality; and the list is not a long one—no longer, we believe, than the success of vaccine therapy justifies. All low-count vaccines have been cut out, so that now the practitioner can administer any dose he may decide upon by measur-

ing it out in his syringe from a 5-ce or 20-ce vial containing a concentrated product. Only two vaccines in the P.D. list contain less than a thousand million organisms in each cubic centimeter, while some of them contain as many as five thousand million.

A VALUABLE G-U TONIC.

"I am prescribing Sanmetto in many of my cases, more especially as a G-U tonic and corrective. I find it a meritorious product, and I will say here—not to prescribe it where indicated is doing a great wrong to patients." *From an unsolicited letter received by the Od Chemical Co., New York City.*

SAL HEPATICA.

This preparation is an agreeable effervescent saline laxative and uric acid solvent, and has rapidly gained the favor of physicians generally. It has a combination of lithia and sodium phosphate with the laxative salts similar to those found in the most famous European bitter or purgative waters. Sal Hepatica can be employed as a laxative and eliminant of irritating toxins with safety and satisfaction in inflammatory conditions of the bowels, and is worthy of a prominent place in the treatment of diarrheas of infancy and childhood.

ARHEOL.

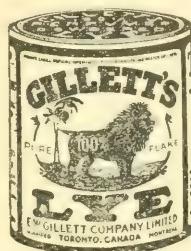
The therapeutic value of Arheol is due to its containing a pure and active sandalwood oil. As such, it is one of the best agents in the treatment of inflammations of the urinary tract. It is also a valuable preparation to use whenever a balsamic is indicated. In gonorrhea, Arheol is especially valuable to alleviate pain and reduce inflammation during the early and acute stage of posterior urethral involvement. It also has a beneficial effect in the subacute and chronic forms, as well as in acute and chronic cystitis. To sum up, Arheol is a pure balsam of constant composition, and of higher potency than plain commercial sandalwood oil.

Hospital Superintendents

Should instruct their
Nurses and domestics to use

GILLETT'S PURE FLAKE LYE

for disinfecting sinks, closets and drains. It is also ideal for the cleansing of urinals and bed pans—in fact any vessel that requires disinfecting. Gillett's Flake Lye should always be used for scrubbing hospital bath tubs and operating room floors.



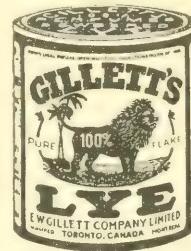
For cleansing and disinfecting, dissolve one tea-spoonful of Gillett's Lye in two gallons of water. The fine crystal flakes dissolve instantly in hot or cold water.

Beware of Imitations

Made only by

E. W. GILLETT COMPANY LIMITED
TORONTO, CANADA
WINNIPEG

MONTREAL



Pure and Delicious

BAKER'S COCOA



Is a most satisfactory beverage. Fine flavor and aroma and it is healthful.

Well made cocoa contains nothing that is harmful and much that is beneficial.

It is practically all nutrition.

Choice Recipe Book Free.

Walter Baker & Co., Limited

DORCHESTER, MASS.

Established 1780

MONTREAL, CAN.

REGISTERED TRADE-MARK

PHILLIPS' MILK OF MAGNESIA.

The Grand Prize which was awarded to Phillips' Milk of Magnesia at the recent Brazilian International Centennial Exposition is only an added honor to many which have come to the famous product during its many years of usage as a dependable medical and dental aid—holding the confidence of the world's greatest physicians and doctors of dental surgery.

Director General J. W. Finch, of the American Industrial Pavilion, in writing to The Charles H. Phillips Chemical Company from Rio De Janeiro sent the message: "I wish to congratulate you for the recognition given your product and it is my sincerest desire that all manufacturers and their representatives who have participated in this Pavilion make the most of the prestige gained. The American Pavilion has enjoyed the greatest success of any Pavilion in the entire Exposition and has also been honored with a Grand Prize."

CARE IN THE PRODUCTION OF MILK.

Many cases are on record showing that sickness and disease have frequently been the result of carelessness in the production of milk.

Fortunately, however, recent years have witnessed marked improvements in the methods of handling milk. In fact, one Toronto dairy—The City Dairy Company, Limited—has, since its inception, done everything in its power to safeguard their customers. They recognize what an important part milk can take in the maintenance and improvement of public health and act accordingly. The care exercised by them begins right at the source of supply—the cow. When the milk arrives at the dairy—a dairy equipped with the latest word in milk machinery—it is scientifically pasteurized in the Jenson Coil Pasteurizers. The processes of cooling and bottling are given the utmost attention by the City Dairy Company, Limited.

Such methods as these should be encouraged by every physician, for they contribute materially to the successful promotion of the crusade for better health.

READY MADE PADS.

It is necessary to make most pads and dressings from gauze and cotton, in the hospital. But one style of pad is now available, all made up and ready for sterilization.

These are perineal pads—Curity hospital pads—made of Curity 2A absorbent gauze and a good grade of absorbent cotton. Six pads are rolled compactly, so that storage space required for them is small. Many hospitals have tested carefully the amounts of gauze and cotton required to have pads made in their hospitals, with the conclusion that they are using Curity hospital pads with real economy. Ask the Curity representatives in Winnipeg, Toronto, or St. John, for information about these pads.

Save Money on Your Hospital Stationery and Forms

Hospital charts, loose-leaf ledgers, account books and office supplies, manufactured by us and sold at prices which will surprise you.

—SPECIAL TRIAL OFFER—

To introduce these forms, we make the following offer, good only until January 1st: Clinical Record at 50 cents per hundred
Graphic Chart at 60 cents per hundred

These prices are on the basis of our standard prices per thousand, and are so ridiculously low that you may think that they are not up to standard. As a matter of fact, they are much above the usual standard of quality, and these prices are only possible by reason of the enormous quantities in which they are produced.

All our goods are *absolutely guaranteed satisfactory* or they may be *returned at our expense* and your money will be cheerfully refunded. A trial order solicited.



The R. J. LOVELL CO., Limited

Wholesale and Manufacturing Stationers

144-150 Simcoe St., Toronto

This Trademark is a Guarantee of Quality



Delicious - Healthful

Junket is a dainty, appetizing dessert, very easily made with milk and

Junket POWDER

into a variety of attractive dishes—inviting to the eye, enjoyable to the taste and relished for their delicacy.

Junket, or milk in its most nutritious form, is covered in the Junket Booklet of Tested Recipes. We offer this in the belief that it may be of value in cases where milk in pre-coagulated, easily digested form is ordered.

Copies free on request

Chr. Hansen's Laboratories, Inc.
Little Falls, N.Y.

Canadian Factory: Toronto, Ont.



"Deliciously
Fragrant"

CHASE & SANBORN'S

SEAL BRAND COFFEE

SOLD ONLY IN
½ lb. 1 lb. and 2 lb. Tins

50

A BRAND OF COCOA WITH A DEFINITE FOOD VALUE.

For a patient with temperature, thirst and a parched tongue, accompanied by inability to take ordinary nourishment, there is perhaps nothing so refreshing as a properly prepared cup of cocoa. Cocoa made by a reputable manufacturer has a definite food value. It is nourishing and will sustain, for instance, a typhoid patient for several weeks or indefinitely. A brand of cocoa that has been on the market for many years and has been a favorite prescription of thousands of physicians is that of Walter Baker & Co., Limited, Dorchester, Mass., and Montreal, Que. It is absolutely pure and is put up under the most sanitary conditions. The medical profession of Canada may continue to prescribe it, knowing that any package bearing the name of Baker is "right."

CASH'S WOVEN NAMES

I shall never forget, lying in my bed in a certain hospital in Montreal, an amusing (to me) incident when my nurse went to the closet to get some fresh bed linen, and like old Mother Hubbard found the closet bare; another nurse, in a hurry, having confiscated her allotment; I think the laugh I had over her discomfiture helped me to get well. Before leaving that hospital I suggested a way to overcome these troubles by the simple expediency of marking uniformly with Cash's Woven Names. To-day all linen is marked with little labels like this: "Ward 3"—"St. John's Ward"—"Third Floor"—"Nurses," etc.; result being that each floor, or ward gets its proper allotment. Then, too, the name of the hospital is attached. The linen that goes out always comes back.

To allay the anguish of my nurse I sent her some of these tapes with her name daintily woven on. Was she pleased? You can realize how much, when she was able from now on to identify all her garments, entailing no more losses. Aprons, gowns and clothing all have her name on. So here we are worrying "What shall I give at Xmas?" and here is the answer—a box of Cash's Woven Names, made by J. & J. Cash, Inc., at Belleville, Ont. -

JUNKET TABLETS FOR MAKING INVALID DESSERT.

Junket is rich in food value. It contains no gelatine or cornstarch, and requires no baking or boiling. Junket is recommended by physicians, nurses and dietitians, and is ideal for use in the sick-room. Junket Tablets make a delicious dessert, or a rich, smooth, velvety ice cream, that are most refreshing to any patient. Prepared only by Chr. Hansen's Laboratory, 201 Church Street, Toronto.

UNGUENTUM ASEPTICO

A scientifically prepared antiseptic healing ointment

A compound of **Boric Acid**, **Eucalyptol**, and **Zinc Oxide** in a special ointment base.

Aseptico is particularly indicated in burns, cuts, scalds, suppurative tumors, and ulcers.

As a base for incorporating other ingredients, **Aseptico** has no equal.

The J. F. HARTZ CO., Limited

Pharmaceutical Manufacturers

TORONTO - - -

CANADA

Opinions differ; but

surgeons and hospital buyers agree on certain points. One is the importance of absorbency in gauze.

Consider a gauze sponge. Its purpose is to absorb moisture. Therefore whiteness, even weave, firmness, although essential in gauze, are secondary to absorbency.

Curity standards require that one-half yard of gauze folded into a four-inch square shall sink in eight seconds or less.

Every bolt labelled Curity has this high absorbency, and assures to users the service they expect in gauze.

Curity Absorbent Gauze merits your confidence



Lewis Manufacturing Company
Walpole, Mass., U.S.A.

Selling Agents:

Western Canada, Gibson-Paterson, Ltd., Winnipeg.
Ontario, (Excepting Pt. Arthur and Ft. William) and Quebec.
H. L. Brown & Co., Toronto.
Maritime Provinces, R. H. Paterson, St. John.



**ICE BILLS are
RELICS of the PAST**

TO USERS OF *York* Mechanical Refrigeration

Ice bills and the worries that go with the iced refrigerator are soon forgotten by the Hospital Staff whose refrigeration is produced by a York Mechanical Refrigerating System.

The constant, low temperature produced by Mechanical Refrigeration preserves the foodstuffs placed in the refrigerator in prime condition. York Machines also manufacture economically, the necessary ice for institutional use.

Write us for information and prices

CANADIAN ICE MACHINE COMPANY, LTD
TORONTO MONTREAL WINNIPEG VANCOUVER



The Buyer's Door & Manufacturing Co., Ltd.

Specialists and Manufacturers

- OF -

Hospital Sanitary Doors and Interior Woodwork

Offices and Mills Toronto
366-400 Pacific Ave.

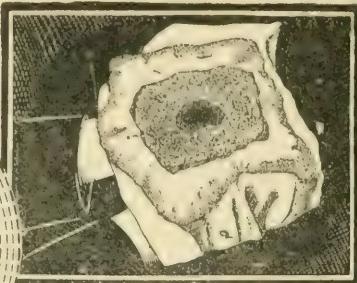
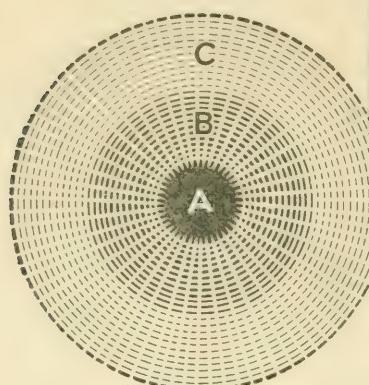


Frederick Lunk, Head Chef at the great Brooklyn Y. M. C. A. pictured above, writes—

"We have used Jell-O here in the largest Y. M. C. A. in the world for the past five years. We like it, and our customers like it. It is easy and quick to prepare, tastes good and delights the eye."

Jell-O means home-and-mother cooking to a great many folks. That, of course, makes it the perfect dessert for wise hospitals, hotels and restaurants. The Institutional Package of Jell-O is this same famous and favorite Jell-O packed in a giant box for greater convenience and economy in serving many people.

The Genesee Pure Food Company of Canada, Limited
Bridgeburg, Ontario



Antiphlogistine poultice, some hours after application to inflamed area. Centre is moist, where exudate has been drawn from the congested tissues. Periphery, covering normal surrounding tissues virtually dry.

This chart shows the Osmotic action of Antiphlogistine

DIAGRAM represents inflamed area. In zone "C" blood is flowing freely through underlying vessels. This forms a current away from the Antiphlogistine whose liquid contents therefore, follow the line of least resistance and enter the circulation through the physical process of endosmosis.

In zone "A" there is stasis, no current tending to overcome Antiphlogistine's hygroscopic property. The line of least resistance for the liquid exudate is therefore in the direction of the Antiphlogistine. In obedience to the same law, exosmosis is going on in this zone, and the excess of moisture is thus accounted for.

Antiphlogistine generates and retains heat upwards to 24 hours

Due to the chemical reaction which goes on during Osmosis between the

c. p. glycerine of Antiphlogistine and the water of the tissues, Antiphlogistine keeps up a steady heat generation.

This sustained heat is invaluable; relieving congestion by increasing superficial circulation, stimulating the cutaneous reflexes, and causing contraction of the deep-seated blood vessels.

Used by hundreds of thousands of physicians the world over.

Antiphlogistine stands alone as a non-toxic, non-irritant absorctor of fluid exudates in superficial inflammations. It relieves deep-seated congestion by inducing superficial hyperemia, through its inherent hygroscopic property, and without irritation.

Let us send you our free booklet "The Pneumonic Lung." Address The Denver Chemical Company, Dept. A, New York, U.S.A. Branches: London, Sydney, Berlin, Paris, Buenos Aires, Barcelona, Montreal.



Antiphlogistine
TRADE MARK
"Promotes Osmosis"



An Invitation To Physicians

Physicians in good standing are cordially invited to visit the Battle Creek Sanitarium and Hospital at any time for observation and study, or for rest and treatment.

Special clinics for visiting physicians are conducted in connection with the Hospital, Dispensary and various laboratories.

Physicians in good standing are always welcome as guests, and accommodations for those who desire to make a prolonged stay are furnished at a moderate rate. No charge is made to physicians for regular medical examination or treatment. Special rates for treatment and medical attention are also granted dependent members of the physician's family.

An illustrated booklet telling of the Origin, Purposes and Methods of the institution, a copy of the current *Medical Bulletin*, and announcements of clinics, will be sent free upon request.

THE BATTLE CREEK SANITARIUM

Battle Creek

Room 271

Michigan

Powerful Antisyphilitic
More active and better tolerated than 606 and neo-606 (914)

GALYL

Adopted by the Civil and Military Hospitals of the Allied Countries

MEDICATION: *Intravenous or intramuscular Injections.*

FRACTIONATED DOSES: 20 centigr. every 4 days. (12 to 14 injections for a course).
MEDIUM DOSES: 30 to 35 centigr. every 6 or 8 days. (8 to 10 injections for a course).

Samples: Laboratories of Galyl, Villeneuve-la-Garenne (France).
Sole Agents for Canada: ROUGIER Frères, 210 Lemoine St., MONTREAL



The Ninth Edition
of our Catalogue

describes and illustrates our complete line of instruments, designed both for the work of the specialist and of the general practitioner. A copy will be mailed upon request.

"E. S. I. Co." Instruments equipped with genuine "E. S. I. Co." TUNGSTEN LAMPS are indispensable for accurate diagnosis. These lamps give maximum illumination with a minimum increase in temperature. Be sure the lamps in your instruments are genuine "E. S. I. Co." lamps.

We shall be pleased to mail a Lamp Sheet on request so you can specify lamps by our numbers, and avoid any possibility of not getting the proper lamps.

Electro Surgical Instrument Company
Rochester, N. Y.

Hygienic Paper Specialties

We are manufacturers of the following items and would be pleased to send you samples on request.

SPUTUM CUP REFILLS
POCKET SPUTUM CUPS
PAPER NAPKINS
PAPER DRINKING CUPS

PAPER CUSPIDORS
PAPER TOWELS
PAPER TABLECLOTHS
TONGUE DEPRESSORS

Stone & Forsyth Co.

67 Kingston St.

Boston, Mass., U.S.A.

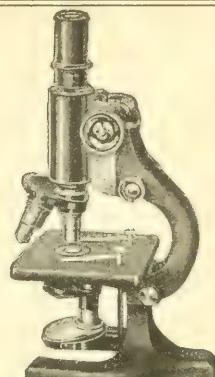
SPENCER SCIENTIFIC INSTRUMENTS

Whether

**Microscopes, Microtomes, Delineascopes,
Haemometers, Haemacytometers or
other Scientific Apparatus**

**MAKE AN INSTINCTIVE APPEAL
TO THE LABORATORY WORKER**

It isn't only their accuracy and utility. It's something in the finish, even more in the design, but additional to all these, it is those little things—clever little devices, which accomplish the same end, but in a better way—exactly the way that the laboratory worker wants them. These are the distinctive features of Spencer instruments, made distinctive because our designers, experienced laboratory workers, possess the laboratory viewpoint.



SPENCER MICROSCOPE

No. 44H

Fully equipped for medical work with two eyepieces, triple nose piece, three objectives, 16 m.m., 4 m.m. and 1.8 m.m. immersion, quick-screw substage, abbe condenser with iris diaphragm, complete in mahogany cabinet.

\$125.00



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BUFFALO, N.Y.



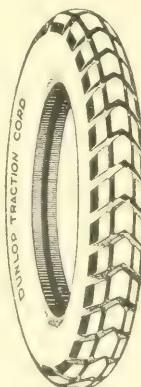
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in buying a Tire is to make sure you get a "Dunlop."

¶ "Dunlop" settles the Quality Question—in your favor.



¶ "Dunlop" gives a definite answer to the mileage question—in your favor.



"29" Years Experience as Tire Makers "to Canada" "29" Years

Supreme

in those points which make for the utmost in quality and purity of bakery products.

You could travel the whole world over and nowhere would you find a bakery more scrupulously clean, more thoroughly and scientifically equipped than the Ideal bakery.

It has kept apace with science and invention. Improvements that add efficiency and further sanitation always find a place with us. The latest addition—the gas-fired travelling ovens—whereby bread is baked to a nicety without the touch of a human hand is the talk of the trade all over Canada.

It is merely a further proof of the progressive ideals upon which the Ideal baking business has been based. The same high ideal of equipment as we have of quality; for Ideal Bread is made from the finest ingredients possible to be obtained.

Knowing this, physicians can confidently recommend Ideal products to their patients.

Ideal Bread Company Limited

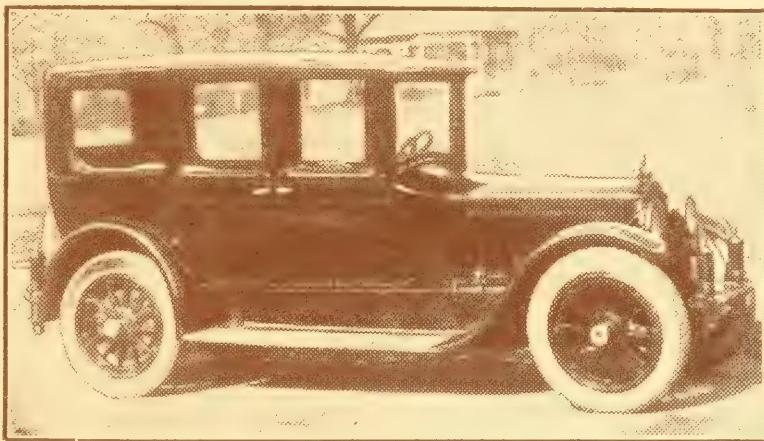
The most progressive baking firm in the Dominion

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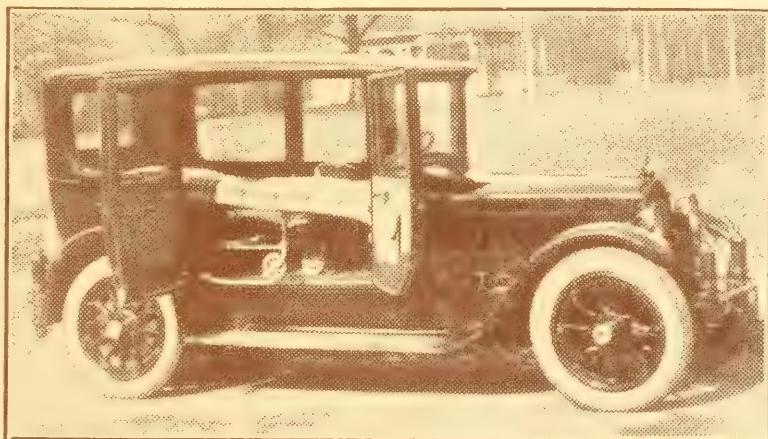


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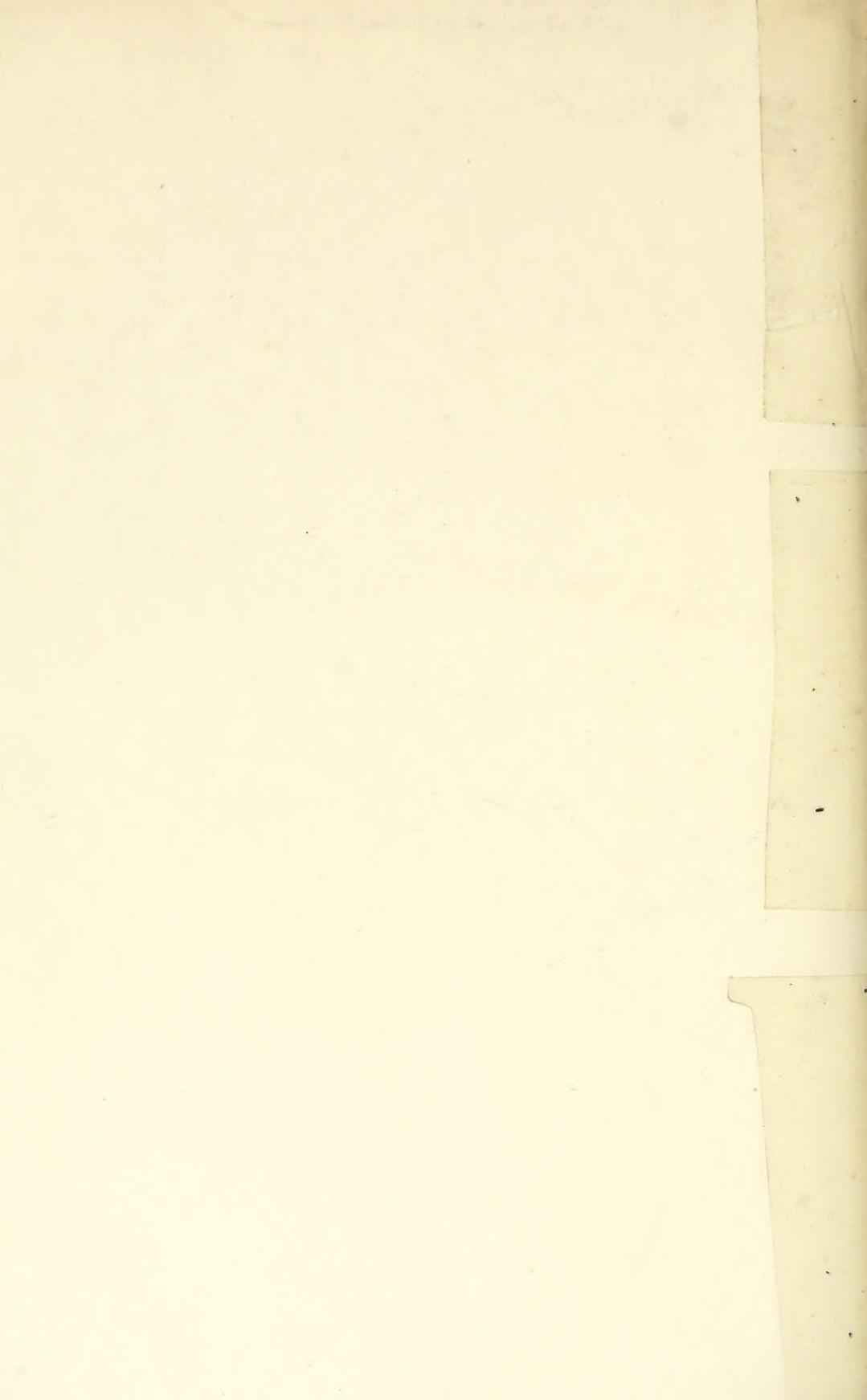
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